Recruitment of 1988 Graduates of North Carolina Family Practice Residencies

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When family practice residents graduate, they will have completed 23 years of formal education. At that point, their goal is to secure a job that will allow them to use their skills to earn a sufficient income while living in a community that satisfies their personal and family needs. Where to locate is obviously a very important decision. If the resident turns to the medical literature for information to help with this decision, he or she will find that several career-influencing factors have been investigated, such as rural background,[1] indebtedness,[2] minority status,[3] predicted specialty,[4] socioeconomic background,[5] and location of medical school and residency.[6] The scope of various practice options is so broad and the literature is so sparse, however, that it is difficult to determine practical generalities about recruitment. Graduating residents are now aggressively approached with opportunities from multiple medical structures: solo private practice, multispecialty groups, independent practice associations and health maintenance organizations (HMOs), emergency departments, and urgent care centers. In this article, the issue of recruitment is examined from the residents' perspective.

METHODS

In June of 1988, just prior to the graduates leaving their residency, the third-year family practice residents in the eight civilian family practice residencies in North Carolina were surveyed. A questionnaire was mailed to each of the 66 graduating residents and each chief resident was telephoned to explain the project and, it was hoped, to increase the response rate. The residents were to indicate their sex, whether their residency was university-based, and their anticipated practice location and type. They were also asked to rank and expand on six factors that influenced their decision-making process.

RESULTS

Forty-seven completed questionnaires were returned for a response rate of 71%. The data were then analyzed using frequency distribution and t tests.

The cohort of respondents was found not to be typical of the national distribution for family practice residents. The sex of the respondents was 42% female and 58% male (the national distribution is 27% female and 72% male).[7] Also, 50% of the residencies surveyed are university-based, whereas, nationally, only 16% of family practice residencies are university-based.[8] These differences may affect the overall results of this survey.

When asked about practice location, 59% of the residents planned to stay in North Carolina. This finding corroborates the findings of LeFevre and Colwill[6] in a 1983 study that shows physicians tend to practice where they train.

The practice types selected by the respondents were categorized into (1) primary care, consisting of solo practice, family practice group, multispecialty group, and HMOs; (2) urgent care, consisting of emergency department and urgent care center practices; and (3) academic, consisting of fellowship and faculty positions. The residents' selection distribution was 57.5% primary care, 19.1% urgent care, and 12.8% academic.

The residents were asked to rank six factors in terms of influence in their decision-making process. The scale ranged from 1 (no importance) to 7 (extremely important). The scores were averaged and the following distribution was created: (1) location 5.89, (2) spouse's opinion 5.75, (3) future colleagues 5.71, (4) salary 4.52, (5) benefits 4.26, and (6) recruitment efforts 3.95. It is important to note that graduating residents considered their spouses' opinion about the potential job to be more important than the salary offered. When these two factors are compared by t

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test, spouses' opinion is statistically more important than salary ($t = .007$, $P < .01$).

When the residents were asked to delineate the factors influencing their spouse's opinion during the recruitment process, five factors were listed most frequently. The factors and percentage of respondents that listed them are as follows: (1) location 49%, (2) physician's schedule 25%, (3) financial package 17%, (4) town characteristics 17%, and (5) job or school opportunities for the spouse 17%.

The survey did not establish general patterns about the third-ranked factor, future colleagues. The fourth-ranked factor, salaries, however, showed a wide divergence. The average beginning salaries for the respondents in each of the practice types are as follows: primary care $50,000, urgent care $90,000, academic fellowship $30,000, and academic faculty $50,000. The salaries ranged from $21,000 in a fellowship to $110,000 in an emergency department. This salary variation helps to explain the trend of graduates going into urgent care settings—19.1% in this survey.

The fifth-ranked influential factor for residents was the benefits package. Of the residents who responded, 91% will be receiving malpractice insurance, 77% will be receiving health insurance, 62% will be receiving life insurance, 60% will be receiving at least 3 weeks' vacation, and 66% will be receiving at least 1 week for continuing medical education (CME).

Though ranked sixth, recruitment efforts did influence the residents' job selection. The most commonly mentioned positive recruitment factor was enthusiasm and the most commonly mentioned negative factors were telephone calls and head hunters (recruitment agents).

CONCLUSIONS

Even though this study has a small cohort, is regional, and is not typical of the national distribution of family practice residents, it demonstrates some very practical points about recruitment of family practice residency graduates: (1) A majority of physicians enter practice where they train—59% in this survey. (2) A trend is developing for new graduates to enter urgent care settings—19.1% in this survey. A major contributor seems to be the $40,000 salary differential seen here. (3) Location is the most significant influencing factor in a resident's job decision. The spouse's opinion is significantly more influential on a resident's decision than the salary offered. (4) There appears to be developing a standard benefits package including malpractice insurance, health insurance, life insurance, at least 3 weeks of vacation, and 1 week of CME time.

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