

Preparing for the Real World:  
An Interviewing Guide for EM Residents

Table of Contents

Forward

Introduction

Chapter 1: The Job Search

Chapter 2: Prospecting and Interviewing

Chapter 3: The Interview

Chapter 4: Questions the Resident Should Ask

Chapter 5: Contracts and Contracting

Chapter 6: The Final Decision

Chapter 7: Tying Up Loose Ends

Chapter 8: The First Year in Practice

Conclusion

## Forward

We appreciate the opportunity and consider it an honor to review the material that is presented in this Guide. As two emergency physicians with over thirty-five years of experience between us, with different perspectives and different professional venues, we have lived through many changes in our specialty and in the healthcare system, and anticipate this changing environment to continue. We did not have a Guide like this to help us when we embarked upon our emergency medicine careers. Hopefully, this excellent document will serve as a resource to each of you and serve you both now and in the future.

Much work went into the preparation of this text, in terms of its planning, design and content. We want to thank Kelly Gray-Eurom, who took the lead role as editor of this endeavor. All of us owe her a great deal of thanks. We are deeply indebted to the many authors who dedicated their time and expertise to write the chapters for this guide. We would also like to thank Beth Brunner, Executive Director of the Florida College of Emergency Physicians, for her excellent leadership of the College and for her role in helping Florida Chapter obtain a chapter grant from ACEP to underwrite this project. Finally, we would like to thank Mr. Jerry Soud for all of his tireless work as the publisher of this text.

As residents in Emergency Medicine, you are about to embark on a career in emergency medicine. Some of you will choose to work in academic settings and others in private practice. Some will be in urban areas, others in suburban areas, and still others will practice in a rural hospital. Each of you will have to work under some business arrangement, whether as an independent contractor or employee, whether working for the hospital, a small group, or a national or regional group.

With all the options you have, your ability to make the best possible decision will hopefully be enhanced by the material presented in this Guide. The authors of the different chapters, in order to help each of you to make the very best decisions, have addressed the challenges and choices that will be facing you.

This Guide is a dynamic document that will change over time. While our future is assured as emergency physicians, the financial, business, and professional arenas in which we practice are changing on almost a daily basis. As such, our specialty and the emergency medicine physicians who practice our specialty will continually be faced with changes and new challenges, requiring constant fine-tuning of our practices.

To this end, we hope that the College will continue to serve as a source of information, ideas and vision for all of us, and for the residents who will be graduating in the upcoming years.

Best of Luck,

Stephen J. Dresnick, MD, FACEP

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Past Presidents, Florida College of Emergency Physicians

## Introduction

by Kelly Gray-Eurom, MD

The decision to entitle this publication *Preparing for the Real World* was not an arbitrary one. It was made to illustrate an important transition that is about to take place in your life as an emergency medicine physician. You have spent the last several years as a resident, part of a fairly exclusive fraternity that has little to do with the world beyond its own doors. Residency has its own set of goals and objectives such as in-service examinations, EKG interpretation, differential diagnosis and patient management skills. That focus is about to suddenly and dramatically change. Now it will be taken for granted that you are up to date on all your medical skills. In "the real world," along with all your medical management skills, you will be expected to understand contract negotiation, the impact of managed care on your hospital, your practice and your colleagues' business plans, group dynamics, medical staff by-laws, state licensing guidelines, CME requirements and credentialing procedures. You are about to enter into the business of Emergency Medicine. And very few of you are ready.

Your faculty of attendings have prepared you to handle a cardiac arrest, a dislocated shoulder or a febrile seizure. Algorithms from ACLS, PALS and ATLS have been etched into your subconsciousness. You have learned the appropriate interventions for critical asthma, congestive heart failure, and airway compromise. Throughout your residency, your teachers and advisors have prepared you to face the challenges of leaving residency and practicing the art of Emergency Medicine; however, in all likelihood, no one has taught you the skills you will need to actually find, secure, and benefit from Emergency Medicine employment after you graduate.

This lack of preparedness creates anxiety, frustration and confusion when residents begin searching for employment. Business concepts are foreign entities. More questions than answers arise. Where do I start? How do I find out who to contact? What materials do I need to send? Am I being taken advantage of? Many residents simply take the first job that looks good on paper because they are not sure what else to do, and are afraid of losing what appears to be a good opportunity. The fear of losing out is a poor way to make long term career plans.

Recent studies examining the turnover rate of emergency medicine physicians illustrates this lack of preparedness. Both Anwar<sup>i</sup> and Hall<sup>ii</sup> et.al. found an attrition rate of approximately 5% among emergency medicine residency graduates. Some residency directors estimate 60 - 70% of their graduates will switch jobs with-in the first two years of graduation. Shift work, workload pressures, malpractice issues, consultant conflict and financial concerns are a few of the reasons cited for job turnover. And why? One reason is because the right questions were not asked on interview day and during contract negotiation.

Emergency Medicine can never hope to have a significant impact on hospital committees, medical staffs, state legislation and national health care policies if the specialty continues to be characterized as a transient population of physicians who make short-sighted decisions at the start of their careers. It does not have to be this way. A little knowledge about the business of emergency medicine goes a long way in ensuring overall career choice satisfaction.

This publication is designed to provide you with the ins and outs of the job search process. It will attempt to make sense of the confusing world of independent contractors, recruitment firms, and hospital employment groups. It will guide you through your first business interview and offer you tips on how to get through your first contract negotiation. It will help you make your final decision about selecting a position. Also included are a few words of wisdom about tying up loose ends once you have selected a job and a few thoughts on your first year out of residency. This knowledge will aid you as you search for your place in the professional world of emergency medicine. Our goal is placement into a secure job that is beneficial to you personally, your employer and the community you serve. The authors of this publication all have been exactly where you are now; armed with the same questions and uncertainties. Some changed jobs several times before finally figuring it out. Our profession represents both academia and the private sector. Some work for mega groups, some work for hospitals and other are independent contractors. We are single and married, male and female, veterans of the business and recent grads. Our goal here is to provide you with a knowledge base from which to start your own search for the perfect job.

The authors gratefully acknowledge the support of the American College of Emergency Physicians for making this publication possible. We are deeply indebted to Beth Brunner, CAE for creating and organizing this project. And on a personal note, we say thank you to Marilyn Meyer, without whom this project could not have been completed.

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<sup>i</sup> Anwar, RH. A longitudinal study of residency-trained emergency physicians. *Ann Emg Med.* 1983; 12:51-55.

<sup>ii</sup> Hall, KN. Factors associated with career longevity in residency-trained emergency physicians. *Ann Emg Med.* 1992; 21:291-297.

## Chapter I The Job Search

by Maureen Campbell, DO and Michael J. Zappa, MD

### Preparation for the Job Search

The first step in preparing for the exciting, yet often bewildering task of finding your first real job in emergency medicine is putting together your curriculum vitae (CV). Your CV will serve as your introduction to any employer. It needs to appear professional, informative, and easy to read. A good example of a CV appears at the end of this chapter.

Once your calling card is complete (the CV!) you must come to some definite conclusions about your wants, needs and desires as well as those of your spouse, children, and extended family, if applicable. If you have a spouse, you must know if they will require a job as well. Having children forces other considerations regarding location such as age of the population, quality of schools, etc. One must also decide if it is important to be near parents or siblings.

### Compensation

For residents preparing to enter the real world of emergency medicine, salary is obviously going to influence interest in a particular job. Hopefully, this publication will help you realize that there are many considerations that influence job choice, although salary is a significant component.

Salaries in emergency medicine vary by area of the country. Once you have decided where you would like to live, make inquiries about the salary ranges (low, middle, high) for emergency physicians in that particular locale. This can be done by contacting colleagues whom you may know, looking up graduates from your training program, or even making "cold calls" to emergency physicians in that area. With this data in hand, decide the minimum salary you would be willing to accept.

Finding the salaries in any particular area may seem simple, but difficulty occurs in categorizing compensation as low, middle, or high. This becomes complex because sometimes salaries are reported annually and sometimes on an hourly basis while some are paid as independent contractors and others as employees with various levels of benefits. The simplest and fairest way to rank salaries is to compare **adjusted** hourly rates. To arrive at these figures will take a bit of work. The easiest way to appreciate this process is to work through the following example.

Job A is offering \$100.00 per hour as an independent contractor. Job B is offering \$150,000 annual salary as a paid employee.

**Question #1:** How many hours will I work each year?

Job A: 12, twelve-hour shifts/month = 1,728 hrs/year  
Job B: 36 hrs/week, but 4 weeks paid vacation = 1,728 hrs/year

**Question #2:** What is the base salary rate?

Job A: >\$100.00/hr  
Job B: \$86.80/hr (\$150,000 divided by 1,728 hours)

**Question #3:** Who pays for malpractice insurance?

Job A: You do  
Job B: Employer does

**Question #4:** Is the insurance claims made or occurrence type?

Job A: Your choice  
Job B: Claims made

**Question #5:** Who pays for the "tail" (extended reporting endorsement) for the claims made policy?

Job A: You do  
Job B: You do, unless you stay at the job five years

**Question #6:** What is the cost of malpractice insurance for emergency medicine in this particular geographic area?

A claims made policy will cost \$7,500 per year for the first year and increase annually to \$22,500 by the fourth year and level off. The extended reporting endorsement (tail) will cost twice the annual premium.

An occurrence policy will cost \$18,000 per year annually.

Remember, the information above is only an example. Insurance rates and availability vary widely throughout the country. The best way to verify these costs is to call several malpractice carriers in the area and get quotes.

Completing the answer to question #6, the approximate annual cost will be \$18,000-\$22,500 or \$20,000, translated into an hourly cost of \$20,000 divided by 1,728 hours or \$11.

**Question #7:** Who pays for health insurance?

Job A: You do  
Job B: Employer

**Question #8:** What is the cost of health insurance in this area?

Once again, the best data is obtained from calling insurance companies directly and getting a quote.

\$4,000.00 annually or an hourly cost of  $\$4,000.00/1,728$  hours which is \$2.31 per hour

**Question #9:** Who pays for disability insurance?

Job A: You do

Job B: Provides a \$2,000/month benefit (not including a supplemental policy)

**Question #10:** What is the cost of disability insurance?

There is great variation here depending on the amount as well as type of insurance

\$400 annually for a \$2,000 monthly benefit or  $\$400/1,728$  hours which is \$0.20 per hour

**Question #11:** Who pays for life insurance?

Job A: You do

Job B: You do

**Question #12:** What about retirement plans?

Job A: As an independent contractor you can put away up to 15% of your annual income to a maximum of \$22,500 in a tax deferred plan.

Job B: Employer will put away \$9,000 annually into a retirement plan for you, which becomes yours only after five years of service. This translates into an hourly benefit of  $\$9,000/1,728$  hours which is \$5.20

**Question #13:** Are there bonuses?

Job A: Possibly, but not guaranteed

Job B: None

**Question #14:** Is there any profit sharing or partnership?

Job A: There is profit sharing after two years

Job B: None

This is not translated into an hourly benefit because there is no guaranteed dollar amount.

**Question #15:** Is there any reimbursement for CME?

Job A: No, but there is no limit to how many conferences one may attend and

have tax write-offs for the expenses

Job B: \$2,000 per year which translates into an hourly benefit of \$2,000/1,728 hours which is \$1.15

To compute the adjusted hourly rates, please refer to the following table:

	Job A	Job B
Hourly Base	\$100.00	\$86.80
Malpractice Insurance Benefit	0	\$11.00
Health Insurance Benefit	0	\$2.31
Disability Insurance Benefit	0	\$ .20
Life Insurance Benefit	0	0
Retirement Benefits	0	(\$5.20)*
Bonus	?	0
Profit Sharing	?	0
CME	0	\$1.15
Adjusted Hourly Rate	\$100.00	\$101.46 (\$106.66)*

\* Only if you are at job greater than five years.

One can easily see that from a purely monetary standpoint, Job A and Job B are essentially equivalent.

The decision between being an independent contractor versus an employee must be evaluated by each individual based on each different job consideration.

### **Advantages of Independent Contractor**

- ?? May be able to save more money tax deferred for retirement
  - ?? Can write off expenses for CME conferences
  - ?? Can write off expenses for professional memberships, subscriptions, and business related equipment
  - ?? Can write off expenses for vehicle used for business purposes.
  - ?? Can choose one's own insurance e.g. malpractice, health, disability, etc.
- Advantages of Employee
- ?? No hassle of quarterly estimated taxes



- ?? Paid vacation
- ?? No payroll finance hassles (social security, FICA, etc.) or benefits management.

## **Location**

The location of the practice opportunity is one of the most important factors in evaluating a potential job. The area should be compatible with your general lifestyle and interests. Your decision must consider the following:

### **A. Setting/Housing Costs**

Urban  
Suburban  
Rural

Be sure you can afford to live in the area on an emergency physician's salary i.e. you may not be able to live in Beverly Hills.

### **B. Hobbies/Culture**

By looking at the last item above, one can gain the insight needed to analyze each of the considerations above. Simply answer one question. What do I like to do on most of my days off?

## **Workload**

How hard you will have to work at a particular job is another very important factor to consider. There are a number of figures which you should obtain.

- A. Annual ED Census
- B. Average Census for Day Shift
- C. Average Census for Night Shift
- D. Number of Physician Coverage Hours Per Shift
- E. Number of Allied Health Personnel Coverage Hours per shift (e.g. PA, ARNP)

It is important to have these figures and compute the average number patients you will see per hour for yourself. Often physician's perceptions (or employers) are inaccurate.

An example computation follows:

- ?? Annual Census - 30,000 patients
- ?? Average Daily Census - 82 patients
- ?? Day Shift - 50 patients
- ?? Night Shift - 32 patients
- ?? Physician Coverage 19 hours for day/17 hours for night

- ?? Average Number of Patients Per Hour:
  - Day Shift  $50/17 = 2.94$
  - Night Shift  $32/17 = 1.88$
  - (Shifts run 12 hours, 7-7. Double coverage noon - midnight)

Acuity must be taken into consideration along with the average number of patients per hour. This is determined by knowing the admission percentage (average 10%-15%) and the breakdown of patients by Evaluation and Management Codes 99281, 99282, 99283, 99284, and 99285 (i.e. Levels 1-5). Level 1 is the simplest, briefest visit and level 5 is the most complex. An emergency department with the majority of visits at level 3 obviously has a lower acuity than a department with the majority of visits at levels 4 and 5. Similarly, an ED that admits 20% of its patients or more has a higher acuity.

### **Demographics**

Determine the population served by any hospital where you are considering a job— young, elderly or in between. Try to find out the percentages of ED patients in each of the specialty areas such as medicine, surgery, OB/GYN, pediatrics, orthopedics, trauma, and psychiatry.

### **The Hospital**

Determine the hospital's overall reputation. There are multiple sources to reveal this:

- ?? Friends, family in the area
- ?? Employees of local restaurants where you might dine while visiting
- ?? Airport personnel, cab drivers
- ?? Physicians, nurses (ask where they take their family)

Find out the composition of the medical staff. This can easily be done by calling the medical staff office at any hospital. Important information to obtain includes:

- ?? Total number of physicians on staff
- ?? Total number board certified
- ?? Is board certification required?
- ?? What specialty departments are there? e.g. Medicine, Surgery, OB/GYN, Pediatrics, Psychiatry, etc.
- ?? What specialty divisions are there? e.g. gastroenterology, pulmonology, cardiology, neurosurgery, ophthalmology, vascular surgery, orthopedics, plastic surgery, otolaryngology, etc.

Focusing on the emergency department itself, there are many details that should be known:

- ?? Is Emergency Medicine a full department in the medical staff organization? Ideally, it should be to allow for necessary clout. However, there are a significant number of facilities where this is not the case.
- ?? How does administration perceive the Emergency Department? Is it a loss leader or is it seen as the window to the community?
- ?? What is the Emergency Department's physical plant like? Is it conducive to a smooth flowing Department? Are there enough beds? The age old minimum standard says one bed for every 2,000 patient visits annually.

In reality, most Emergency Department patient flow is unevenly dispersed throughout the day. In conjunction with ever increasing customer service orientation in ED's this dictates one bed for every 1,250 patient visits annually.

- ?? How is the ED staffing (non-physician)? Is the ratio of RN to LPN to Tech/Medics appropriate? What is the level of training and certification of the staff (i.e. ACLS, PALS, CEN, etc.) What about secretarial/ward clerk support? Is it provided on all shifts?
- ?? What is the reputation of the ED's nurse manager? Aggressive? Progressive? Respected?
- ?? Does radiology provide good service to the ED? Are there enough techs and suites for emergency patients? Is CT, ultrasound, and nuclear medicine available around the clock?
- ?? What is laboratory turn around time for tests from the ED? Ideally, it should be one hour or less.
- ?? How long has most of the ED staff been at this hospital? Has there been a lot of turnover lately? Why? Frequent turnover can be a negative, but may also be a positive. One must determine why. If the staff is overworked and not supported, this is clearly a negative. If there had been a lot of "dead wood" not willing to move and grow with a growing ED, then it is a positive.

## **Group Type**

There are essentially different models of groups in Emergency Medicine:

1. Contract management companies
2. Independent groups
3. Hospital Employee
4. Hybrid

There are advantages and disadvantages with each of these, along with stereotypes based on fact as well as fiction.

A large number of emergency physicians practice with contract management companies. A contract management company is typically a regional or national corporation that supplies emergency physicians to hospitals. This corporation is able to provide support service to its physicians, such as billing, credentialing, accounting, security, and certain benefits. Some companies are privately owned,

others publicly traded. Each emergency physician contracts with the corporation, which in turn has a contract with the hospital. Obviously, with the multitude of hospitals in the country and the various contract management companies, each situation must be analyzed independently.

Independent groups are corporations, partnerships or associations that have a contract with a hospital to provide emergency physician coverage. These situations are increasingly harder to find. Group structure varies from equal partnerships to limited partnerships to solo contract holders. Typically these groups do not have many non-physician employees (1-2) people) and must pay for services such as billing, accounting, and legal. These small groups may be able to provide better physician reimbursement than a contract management corporation because of less overhead. Once again, situations vary widely throughout the country, and the specifics of each must be critically analyzed.

Hospital employee situations are becoming more popular again. In this situation the emergency physician is contracted directly to the hospital with guaranteed compensation, benefits, and vacation.

Hybrid groups refer to those situations in which a group has some features of the independent group practice and has more than a few hospitals. However, they are not as large as the contract management companies. These groups share some of the advantages of each of these models. The following tables highlight some of the advantages and disadvantages of contract management groups, independent groups, and hospital employees.

### **Contract Management Company**

ADVANTAGES	DISADVANTAGES
Personnel and Resources for Marketing	Rapid physician turnover
Physician has no business headaches, just worries about medicine	Not all physicians are board certified in emergency medicine
Economy of Scales may get better billing and insurance rates	Little to no say in the running of the practice
May get better rates with MCO's	Feeling of lack of control of future
Has financial resources to withstand fluctuations in reimbursement	Difficulty with acceptance as equals within the medical staff (e.g. just "contract docs")
Typically provides malpractice insurance with tail coverage included	No productivity incentive
Can provide career ladder opportunities for the physicians	

## Hospital Employee

ADVANTAGES	DISADVANTAGES
Job security	No sense of ownership
Paid benefits	No productivity incentive
No business headaches	Perception as less than equal member of medical staff
Sheltered from reimbursement fluctuations	

## Independent Group

ADVANTAGES	DISADVANTAGES
Often homogenous group of emergency physicians (i.e. all board certified)	High degree of contract maintenance (many people to please regularly to secure contract)
Usually well integrated into Medical Staff	Potentially limited resources to withstand fluctuations in reimbursement
Sense of ownership and commitment	Limited ancillary resources
Growth and productivity incentives	

Clearly, there is no perfect model for the group practice of emergency medicine. In assessing any group, one must look for a situation with the most positives and tolerable negatives. The following is a list of important points to know about any group.

1. How long have they been in existence?
2. What is their structure?
3. How long have they had the contracted hospital where you are considering working?
4. How long until the contract is up for renewal?
5. What has physician turnover been like?
6. What is the guaranteed compensation?
7. Is there profit sharing or partnership? If so how is this determined?
8. Is there any productivity incentive?
9. What benefits are provided?

10. How is the schedule determined? Is it fair?
11. How is vacation scheduled?
12. Who pays for malpractice insurance?
13. Who pays for an extended reporting endorsement; i.e. tail coverage?
14. What are the training and qualifications of the other emergency physicians?
15. Who determines if there is adequate ED coverage?
16. Are there any on call responsibilities?
17. Who has say in the running of the emergency department?
18. Who has say in the running of the business side of the practice?

## B. The Process

The time to start the process of the job search is in your junior year, by observing the seniors going through the process. By the fall of your senior year determine your area of geographical preference and your desired salary range. Next, start checking the sources for jobs.

- ?? Prior Graduates
- ?? Classified Ads e.g. Annals of Emergency Medicine, State Newsletters, etc
- ?? EMRA at ACEP
- ?? Calling EDs in your geographic area of interest
- ?? Recruitment firms
- ?? State Meetings/Conferences

A cover letter introducing yourself and your availability date should be forwarded along with your CV to each potential lead. The cover letter should request a response if they are interested or should state that you will follow this with a phone call in one week. If the phone contact is positive, an interview should be scheduled. If you are still interested in the position after the interview, send a follow up letter reaffirming your interest in the position.

## C. Pearls and Pitfalls

- ?? Often the best jobs are not advertised.
- ?? Recruitment firms cost the employers a good deal of money...most good jobs do not need to use them.
- ?? Never take a job without a contract.
- ?? Do not be afraid to negotiate.
- ?? Promises not written were never made.
- ?? Look at the physicians you will be working with as you would look at a potential spouse.
- ?? The best job is . . .
  - o Where you want to live
  - o At a hospital with the resources you will need, serving a population you will enjoy
  - o One which fairly compensates you
  - o Where you have a say in the practice

- Where your colleagues are as well trained as you are
- Where you can make a difference

## **Sample Curriculum Vitae**

Your Name, Degree

Mailing Address

Telephone Number

### **PERSONAL**

Date of Birth

Place of Birth

Health Status

Marital Status/Children-ages

Languages Spoken other than English

### **RESIDENCY**

University

Address

PGY I-IV Emergency Medicine Dates

### **EDUCATION**

Medical School

Address

Degree, Date

### **CERTIFICATIONS**

State License Number

Diplomat National Board Medical Examiners, #, etc.

ACLS Instructor, etc.

### **WORK EXPERIENCE**

Hospital (e.g. moonlighting or additional specialty)

Address

Position, Dates, full or part-time

Job relevant to this career (RN, paramedic, teacher, etc. or one which you would want to discuss in an interview)

### **HONORS**

### **PUBLICATIONS**

Title

Journal Vol Page Date

### **PRESENTATIONS**

Lecture Title

Location, Date

## APPOINTMENTS

Committees, etc.

## PROFESSIONAL AFFILIATIONS

ACEP

AMA, etc.

## GENERAL INTERESTS

Hobbies



## **Chapter II Prospecting and Interviewing**

by Kelly Gray-Eurom, MD and Shawna J. Perry, MD

### **Preparation for the Job Search**

More than likely, the last time you interviewed for a job was when you sought a position as an emergency medicine resident. This was a very unique process because of its focus. The objective was to obtain the best educational experience for yourself in emergency medicine, with little emphasis on your wants, needs, or desires. Most medical students are not thinking of "being happy" but of joining a program where they will be the "least unhappy."

Additionally, the locus of control was with multiple outside sources and there were innumerable variables that could impact the outcome. You had little or no control over the majority of these variables. For instance, did every program get all your letters of recommendation in time for the review of your application? What mood was the residency director in when he or she read your application? Despite our best efforts, we resigned ourselves to the fact that no matter how undesirable the outcome, it was for only a limited period of time, and the reward of being a board-certified emergency medicine physician was worth it.

However, this time the objective is markedly different. Now you are seeking the best group possible to earn a living with skills learned in residency. Now your wants, desires and needs are foremost, as you seek a practice setting where you will be satisfied. This does not mean that there are no trade-offs as you seek that 'perfect' fit. What it does mean is that this time there is more at stake. Dissatisfaction with your medical practice can be costly, with far-reaching consequences to you and even your loved ones.

Research by RH Anwar in 1983 showed that the two-year attrition rate for residency trained emergency physicians was 5%. More recent research has shown that the longevity for residency trained emergency medicine physicians is related to satisfaction with training decisions, job satisfaction, levels of income and board certification status. Your job satisfaction and longevity in the practice of emergency medicine is impacted not only by thorough scrutiny of groups you are considering, but also by realistically looking at yourself and what practice constructs would be most compatible with you.

The interview process you are now embarking upon is vastly different from that of residency training in one other crucial aspect. You are seeking to enter into a professional work relationship with your employer that is governed by the rules of business. As such, you will be expected to adhere to standard business practices. Having spent the last twelve years or so becoming a physician, the world of business may not be familiar to you. Prospective employers will, however, expect you to know and follow their guidelines for obtaining employment. Remember that this is not medical school. It is not residency. It is your career and you are entering the business of Emergency Medicine.

All residency programs teach high quality, state-of-the art emergency medicine, but few teach students how to navigate the process of finding that first job. Faceless medical school professors or residency match computer programs no longer plan your future. You are the crucial factor now. The next two chapters will offer some signposts to strategically pilot you through this critical process.

## **Prospecting For A Position**

As discussed in the introduction, the first and most important research has to be conducted on **yourself**. Where to look for prospects depends on what you are interested in and what you identify as priorities. You must ask yourself a series of questions that directly address what you want. To honestly answer them will require soul searching. Discussions with mentors, colleagues, family and friends who know you well is highly recommended. Key questions are:

### **1. Where do you want to practice emergency medicine?**

Is there a specific geographic region of the United States and its territories where you wish to live? Do you want to live in an urban, suburban, or rural setting? Does it matter?

### **2. Are you interested in an academic or non-academic setting?**

Do you enjoy **teaching**? If so, does it matter to whom (e.g. nurses, medical students, emergency medicine residents, etc.)?

### **3. What type relationship would you like with your group?**

Independent contractor? Partnership tract? Employer/employee? Mega-group?

Independent group?

### **4. Are there any particular practice settings you prefer or dislike?**

For instance, do you prefer large volume, small volume, or more than one emergency department covered by the group?

Your answers to these four questions will help you to focus on key information about potential job openings that will be most beneficial for you.

## **Where To Find Out About an Opening?**

There are multiple sources for finding out about job opportunities in emergency medicine. The methods listed below will aid you in obtaining this information. They are listed in any particular order and you should utilize as many as necessary.

**Word of Mouth:** Frankly, the field of emergency medicine is rather small, and many groups will "put out the word" among friends and colleagues around the country regarding job openings. Be sure to canvas any emergency physicians you know, whether

in academic or private practice for possible openings. This information usually is available before any print ads or recruitment firms are aware.

Definitely talk to the emergency medicine attendings from your own training program. Alumni will frequently call their old residency program first seeking senior residents or recent graduates because the quality of graduates is well known to them.

**Printed Materials:** This includes advertisements in emergency medicine journals, as well as flyers/letters in the mail. Also peruse other major medical journals like JAMA, The New England Journal, and Annals of Internal Medicine. Some groups will advertise in these publications as well.

**Recruitment Firms:** These are companies or divisions of employment services that act as "middlemen" between the physician and emergency medicine groups nationwide. The recruiter does most of your legwork, including writing your CV if requested. These firms circulate your CV based on the specifications you give on practice type, and then contact you with any pertinent information. This is very helpful if you are short on time or having problems getting information on a specific area where you wish to practice.

There are a few down sides to the use of a recruitment firm. You have little control over the pace of the search or the methods used by the firm. The listings are not all inclusive for a particular area of interest to you because these firms only list those emergency medicine groups that contract for their services. They are frequently used by large mega-groups. Finder's fees are paid to the firm by the employer should you be hired. Fees may range up to \$20,000 per new hire. These fees frequently are deducted from your signing bonus, moving expenses or salary. If you wish to use a recruitment firm, keep in mind that your range may be limited and you might not want to rely on them solely for information.

**Emergency Medicine Conferences:** Local, state, regional, and national emergency medicine conferences are a hot bed for job opportunities. ACEP, SAEM, AAEM, EMRA, etc., will all have employment boards where positions are listed. Some will be scrawled on a small piece of paper with only minimal information and a hotel phone number. Do not be turned off. Some of the more desirable practices will have a low-key approach and could turn out to be a perfect match. Try to attend at least one of the national conferences in your senior year of residency.

**Emergency Medicine Organizations:** National and regional chapters of organizations such as ACEP and AAEM will have clearinghouses for employment opportunities around the country. Do not hesitate to contact them.

**Telephone Book:** If you know of a specific region or city where you want to practice, you can use a direct method of finding out about openings by calling groups yourself. You can obtain the names and numbers of the hospitals in your region of interest from the telephone book at the local library. Call on a weekday and ask to speak to the medical director or president of the group. Make sure to introduce yourself as a graduating emergency physician, express your interest to practice in the area and ask if they have openings. This can be a very effective method of finding out about opportunities in parts

of the country where you have few contacts and you are not interested in using a recruitment firm.

Although it sounds uncomfortable to make a cold call, you will find most of the groups you speak with congenial. Frequently, they can be a source for other openings in the area if they have nothing available.

**Internet:** Although not currently widely used by EM groups, there are some physician employment bulletin boards out there. You just have to search the Net.

### **Where To From Here?**

Before getting to this point you want to make sure your CV is already completed and ready to mail out immediately to groups that interest you. See Chapter II for discussion on how to prepare a well-written resume.

**All of your CV's must have a cover letter.** The purpose of a cover letter is to introduce yourself and your CV to your prospective employer and to demonstrate your ability to communicate.

An effective cover letter has three main parts: Introduction, body, and conclusion. The **introduction** should identify the type of job you are interested in, your career objectives and how you heard about the opening. The **body** should tell why you are interested in working for a particular group, sell your skills, and highlight any experience or achievements that would make you the ideal candidate. The **conclusion** should refer the reader to your resume, thank them for their time and consideration, request an interview at the reader's convenience, and state clearly how you can be reached.

A few rules for the cover letter are:

- ?? Use standard business format
- ?? Type on paper that matches your CV
- ?? Proofread carefully
- ?? Be formal, polite, honest and assertive
- ?? Keep a copy of each letter you send out as a reference
- ?? Address the letter to a specific person if possible. If not address

"Dear Sir or Madam" or "To Whom It May Concern"

- ?? No more than one page in length

A sample cover letter follows this section.

### **Sample Cover Letter**

Dear Dr. Jones:

I am writing to express my interest in the position of Emergency Medicine physician your group advertised in the November issue of Annals of Emergency Medicine. I am a senior Emergency Medicine resident at XYZ Medical Center in XYZ, Florida, I am graduating in June of 1998 and seek a career as an Emergency physician in a community hospital.

I have been very active in the practice of emergency medicine and founded our EM Interest group at University of ABC. I have been very involved in the politics of EM in Florida as the EMRA rep for our residency, attending EMS day in Tallahassee all three years of my residency. I also chair our resident QA committee, and serve as a member of the hospital QA committee.

Enclosed is my curriculum vitae. Thank you in advance for your time and consideration and I look forward to hearing from you. I can be reached at the (555)555-5555 day or night.

Sincerely,

EM Physician, MD

Once all the legwork has been done and an interview has been granted, there are only two words to live by during this anxiety-provoking portion of the job search:

### **Be Prepared!!!**

?? **Make sure to investigate the group you are interviewing with.** When you demonstrate knowledge of the organization, you set yourself apart from other applicants. Only 15% of job seekers research the companies before they interview with them. This research gives you information and enables you to exercise your right to "interview the group."

?? **Plan your wardrobe ahead of time.** This is a business interview and the conventional rules apply. Keep it conservative and simple. Make sure clothes are neat, well pressed and clean. You want to come across polished, so avoid flashy outfits, loud ties, heavy perfume or cologne and big jewelry. Incorporate a briefcase or purse into the ensemble.

?? **Try your clothes on well ahead of the interview to ensure the proper look.** Ask yourself the following questions: Is this the impression I want to make? Am I comfortable? Do my socks go with this suit? Does my bracelet interfere with a good handshake? Do I have something to hold any papers I might receive during the interview day?

?? **Make sure you have a copy of the itinerary before you make your travel arrangements.** Some interviewers like to have you meet other members of the group in a more informal setting and will often arrange a dinner the same day as the interview. Others spread the interviews over two days with one day specific for hospital administration. The itinerary can also be used to find out whom you will interview with

and their titles. The secretary for the group can be helpful in answering any questions you may have, so do not hesitate to utilize this person.

?? **Plan your travel time carefully.** This includes your travel time to the city of the interview as well your travel time to the interview site. Arrive the day before so you will be well rested and so you will have a chance to check your route to the interview location to ensure you are not late in the morning. A taxi is frequently the best insurance that you do not get lost. Do not plan your departure immediately following your interview in order to accommodate for any last minute interviews or delays in the interview schedule. Additionally, you do not want to give the impression that you are not very interested in the position by "flying in and out."

?? Bring extra copies of your CV to the interview.

?? Be sure to travel with extra money and clothes in case of an emergency. Carry your interview suit with you onto the plane.

?? Know whether or not spouses or significant others are included in any portion of the interview day before arriving.

Strategic and aggressive preparation in seeking positions in emergency medicine and for the interview process **will pay dividends. It will ensure that you are controlling your interview process and not being controlled by it.**

## **Chapter III** **The Interview**

by Rodney Kang, MD, FACEP and Bobette Fisher

### **Interview Attire**

Interviews are formal business meetings where appropriate attire is essential. The old cliché, "You never get a second chance to make a first impression," still remains true in today's fast-paced business environment.

For men a jacket or suit with tie is the norm. For women a dress or suit with hose is considered customary for an interview. Whatever attire you select should be in a conservative color and style. Large amounts of jewelry, cologne and trendy hairstyles can be turn-offs! Women should avoid wearing too much make-up.

The image you project to the prospective employer remains long after the words you have spoken. Appearance often can be the deciding factor in an interview when you are competing with other physicians.

### **Behavior**

The market has changed radically since your predecessors set out to secure employment after completing their residency training. No longer is an interview just a formality before receiving an offer. If you possess an "all assuming attitude" leave it behind you in the car.

Conduct yourself in a professional manner with everyone you meet during your interview! Secretaries and nurses usually have input after candidates leave. Slang terms and coarse language can be offensive to certain individuals and, needless to say, inappropriate during the interview process.

Be enthusiastic and grateful for the opportunity to meet with fellow colleagues and their support staff. Most practices are not interested in making an offer to someone just looking for a job. Prepare questions prior to the interview. State your long-term goals and emphasize your integrity, honesty and stability. Although an interview can create anxiety, try to relax and give the prospective employer a chance to get to know the real you.

### **What to Expect**

Upon confirming a date and time for an interview, start planning your itinerary. If you are traveling, confirm expenses and any limitations that apply. As an example, most potential employers do not expect you to make first class airline reservations or to rent a full-size luxury car.

Once you arrive at your destination, more than likely your time will be spent a number of ways:

?? Formal interviewing with the leadership of the group

- ?? Touring the hospital and its emergency department
- ?? Meeting other physician members and support staff within the group
- ?? Meeting with hospital administrators and quite possibly nursing staff and medical staff
- ?? Looking around the community
- ?? Checking out real estate costs, schools, etc.
- ?? And possibly spending informal time with the members of the practice

And again, your questions should be prepared prior to your arrival for all situations noted above.

A typical agenda of an interview allows the prospective employer to ask you questions and to thoroughly review all aspects of the practice opportunity prior to the candidate starting with questions. Upon hearing about the group initially, you can temper or adjust your questions. Most of your questions probably will be addressed during the review of the practice.

Be prepared to talk about yourself. For some candidates, this is difficult. Practice prior to your arrival to ensure that your responses reflect professionalism. If necessary, write out a summary of your attributes and rehearse them aloud. Remove the "uhs," "buts" and "ands" from your speech patterns.

During the initial interview the group may or may not discuss compensation. Be patient and avoid asking prematurely for salary information. You do not want the appearance that money is your only motivation for accepting the position. Your objective should be to investigate the total opportunity and determine whether it suits your long-term objectives. However, if the subject of compensation is not brought up you might ask, "May I have a copy of the contract outlining the specific terms of the position?" That should be enough to bring the issue into the discussion.

Prior to the interview, make ample copies of your letters of recommendation and be sure to provide them to the prospective employer, especially if you have a keen interest in the position.



## **Chapter IV**

### **Questions the Resident should ask . . .**

by Shawna J. Perry, MD

One of the central purposes of this guide is to empower you as you pass from the domain of residency into the business of emergency medicine. As we all know, knowledge is power, therefore, it is imperative that you obtain as much information as possible about prospective employment opportunities. The interview is not just an opportunity for the group to see if they like you. It is also a chance for you to get more specific information about the group and its practice. Following are a list of questions that can help you find out about those aspects of a practice that can impact your job satisfaction. Do not hesitate to ask these questions to members of the group if these details are not made clear to you.

1. What type of group is this? How does it work? How are administrative positions assigned? Are there other settings the members see each other besides shift change (i.e. staff meetings, journal club)
2. How long has the hospital contracted with this group? When is it up for renewal? How stable is the relationship between the group and the hospital?
3. What is the group's composition (i.e. male, female, minority)?
4. What are the physician staffing patterns for the ED? Any double or triple coverage times? If so, is it covered by a physician or physician extender (i.e. PA, nurse practitioner)?
5. Which are your busy days?
6. What is the staffing pattern for the nurses, techs, and clerks?
7. What is your average patients-per-hour for the ED physician?
8. How is the relationship between the Medical staff and the ED group? Are they generally supportive? How are conflicts resolved (i.e. chairman of the ED, Chief of Staff?) How about at night and on weekends? Are they prompt on consultations?
9. Do the medical staff see their own patients in the ED? Are they allowed to call in phone orders to the nurses without the ED physician seeing the patient?
10. What is the ancillary support to the ED? For instance, who does your EKG's? Respiratory treatments? Are the Xray and CT techs in-house? Are plain x-rays done in the department? Is radiology available 24 hours a day?
11. Is the ED physician expected to write orders on admitted patients? Is the ED physician expected to provide emergency coverage for the entire hospital while on duty? (i.e. in-house codes, back up for the ICU)?
12. How is the schedule made? Who makes it? What are the shifts? How are the nights weekends and holidays distributed?
13. How is personal leave time addressed (i.e. family emergency, illness, pregnancy)?
14. Who does your billing? Does the group get monthly printout of charges and revenue? Is it shared with the members of the group? How frequently does the billing company meet with the group? Are the ED physicians expected to code their own charts?
15. How much CME time does each member get per year?
16. Are there specific protocols for ED specific actions like rapid sequence intubation, gastric decontamination and charcoal administration, and TPA use?
17. Are the nurses allowed to write orders at time of presentation?
18. Does the ED accept non-urgent referrals from private physicians for IV's, PIC lines, CVP's?

19. What is the volume and average acuity level of the pediatric patients? Is there an inpatient pediatric ward?
20. Do this group provide coverage for any other hospitals?
21. Is there a "back-up system" in place?
22. What are the hospital credentialing requirements and how long does it take?
23. What are the strengths and weaknesses of this group and its practice here?

### **Do's and Don'ts While On the Interview**

**DO** verify any information you already have.

**DO** meet the charge nurse and some of the ED staff, if possible.

**DO** check on the state licensing process. Especially how long, how much and who pays for it.

**DO** try to observe a portion of a shift.

**DON'T** discuss salary unless the interviewer brings it up.

**DON'T** mention any rumors or gossip you may have heard about the group.

**DON'T** smoke or chew gum before or during the interview.

**DON'T** curse during the interview or be too familiar.

**CONSIDER** asking for a copy of the physician contract. This is very tricky, as it is usually not offered until the second interview.

### **Follow-Up To The Interview**

One of the crucial mistakes made by applicants is improper follow-up to the interview. The act of sending a thank-you letter will reinforce the fact you are interested in a position and remind the group of you in case you got lost in the applicant pool. Even if you are not sure if you would take a job if offered, send a letter anyway. The job market is unpredictable and you never know when you may cross a particular group again.

Your thank-you letter should be brief and sent immediately after the interview while you are still fresh on the group's collective mind. If possible mention a special thanks to each person who took time to interview you and some of your strengths as an applicant and your interest in a position. It should be no longer than 2-3 short paragraphs in length.

Follow-up phone calls are acceptable within a reasonable time frame. Do not call any sooner than two weeks after the interview and definitely no sooner than the group told you they would get back with you. Use it as an opportunity to ask any lingering questions you might have and ask if there are any that you can answer for the group. Be gracious and make sure to express your willingness to answer any further questions the group might have or return for a second interview, if needed.

## **Chapter V**

### **Contracts and Contracting**

by Robert L. Wears, MD, MS

When developing a contract, remember that both sides are attempting to gain something. The goal should be mutual satisfaction to both parties. Thus, do not be afraid to reject a contract that is unacceptable to you. The major sources of satisfaction or dissatisfaction with group practices come from the individuals and practice styles of the group, not from contract issues. When evaluating groups as potential employers or partners, use the following screening tests to narrow down the field:

1. Are the other physicians in the group well trained, board-certified, qualified and competent? Would you let them treat your family?
2. Is the group forthright? Will they show you an employment contract? A partnership agreement or corporate bylaws? The contract with the hospital? The books on billings and collections?
3. Is ownership/partnership possible? If so how soon? Will you be on equal footing with the present owners? Must you buy in, and if so, how much will it cost?

If you decide to organize your own group seek appropriate legal and account advice. There are advantages to being an employee as discussed in Chapter II, The Job Search.

### **Organizing A Group**

There are two basic ways of organizing an ED group as a corporation (frequently called a PC or PA) or as a partnership. There are advantages and disadvantages to each, and the final decision should be made only after consultation with an experienced lawyer and accountant, as there may be significant variations from state to state.

### **Partnership**

A partnership is the simplest and most expedient form of organization. Technically, no documents are required to form a partnership, but practically speaking a partnership agreement should be executed. Partnerships are informal organizations, have minimal rules and record-keeping requirements, and do not require legal maintenance in the way corporations do. A partnership typically would divide its income in rough approximation to the partnership interest (e.g., hours worked), and its expenses would be apportioned to each partner accordingly. Each partner is considered self-employed and is responsible for his own taxes, FICA and benefits, which usually are not tax-deductible.

When a partnership contracts with a hospital, or incurs any form of legal obligation (such as a loan, or a judgment against it), each partner is individually responsible for the entire obligation. (This is another version of joint and several liability). For example, if one partner loses a malpractice suit in excess of his limits of liability, the plaintiff may bankrupt him, and then turn

to each of the other partners and bankrupt them as well, until the judgment is satisfied. The same holds true for fulfilling a contract with the hospital, repaying loans, etc. Additionally, business assets held by the partners are not differentiated from personal assets, thus a physician's personal assets are not "untouchable" in a liability action. For this reason, although it is less formal, a partnership is a much more financially intimate relationship than a corporation.

### **Corporation/Associations**

Professional corporations or associations are probably more common than partnerships, although they do not presently offer as great a benefit as in the past. A corporation is a new legal "person." It can be sued, own property, etc., and has a separate existence and identity from its physician stockholders and its employees. If a judgment is returned against a corporation in excess of insurance limits, the plaintiff may bankrupt the corporation but may not then proceed further against the stockholders since the corporation is considered an independent legal entity.

The legal and accounting requirements for corporations are significantly greater than those for partnerships because the corporation must have bylaws and a charter, must issue stock, must have a board of directors, officers, etc. The various stockholders and directors are required to hold regular meetings and must keep records of these meetings. Any major decisions, like opening a bank account, must be validated by a resolution voted on by the board of directors. As a rule of thumb, one should assume that it will cost at least \$1000 to incorporate, and it will cost at least \$500 a year to maintain all the legal requirements a corporation demands.

In organizing a PA, the physicians forming the corporation become the initial stockholders. The corporation then contracts with the hospital and in turn employs physicians (who need not be stockholders) to provide the professional services required. Each physician is paid a salary and may receive certain benefits that the corporation can deduct as business expenses. At the end of the fiscal year any profits are distributed to the stockholders or retained by the corporation to be reinvested.

It should be noted that corporate benefits in general must be uniform. This is a greater problem than it appears. A common reason for conflict in physician groups is an inability to agree on how to manage pooled funds. Physicians with families want generous disability, life insurance, health and dental benefits while those without want the PA to provide the value of those benefits as cash each year. In addition, any deferred compensation plans such as the profit-sharing plan mentioned above must be set up for all the employees of the PA, not just for those who want it.

The advantages of incorporation at present are that it can generally provide enough tax-free benefits to offset its yearly expenses; it also provides some automatic financial discipline since the salaries are fixed and personal income does not vary from month to month. Finally, since the corporation is a separate legal entity, the physician's personal assets are not at risk in a judgment against the group or one of its employees.

Previously, corporations were allowed to set up tax-deferred retirement plans (profit-sharing plans) in which they were allowed to place up to 15% of an employee's gross income each year, but self-employed persons (partners) were only allowed to place a maximum of \$7500 in their plan (Keogh plans); since 1982, Keogh plans are permitted to use the 15% limit, removing the major benefit of incorporation.

## Elements of a Contract

No matter which of the various forms of association physicians choose, there are several items that must be agreed on in any such relationship. Most of these should be covered in the partnership agreement, the corporate charter and bylaws, or the physician-group employment agreement.

1. **Membership:** The method of obtaining full, membership in the group should be specified. While it is unreasonable to think that a new physician joining a group straight out of residency would be immediately offered a full membership, it should be agreed upon that after a certain period of time he or she be given the opportunity. If there is a "buy-in" it should be specified in advance and not be prohibitively high since ED groups in general do not have many fixed assets.

Since a group's major asset is generally its accounts receivable, a fair buy-in amount can be determined by estimating the present value of the accounts receivable. At an interest rate of 6% and for a typical collections curve, the present value of accounts receivable is roughly equal to twice the average monthly cash flow, (or twice the total accounts receivable, divided by the number of months in receivables), assuming that the group ages their accounts properly.

Although it is not commonly done, during the trial period compensation should be roughly equivalent to a full partner's; e.g., no less than 85% of a partner's compensation. If the initial compensation is much less than this, the buy-in, if any, should be proportionately reduced to account for this "sweat equity." Be alert for groups that have classifications of membership. Some may be more equal than others.

2. **Compensation:** The method of compensation for members should be specified. This is usually done via resolution rather than inserted in the partnership agreement or corporate bylaws for purposes of flexibility. If straight dollar amounts are given, find out what happens to any excess revenue.
3. **The Director:** An equitable method of selecting and compensating the group's director should be determined, along with any limitation on his authority (e.g., to borrow money in the group's name).
4. **Resignation:** The method of departing the group should be clear. Since some hospital contracts contain quarterly or yearly adjustments by which the group may be required to return money to the hospital, members leaving before the end of such an adjustment period may have some of their terminal compensation withheld to cover any possible paybacks.
5. **Termination:** Before it is ever needed, a method of eliminating a partner involuntarily should be specified. This may seldom or never need to be invoked but, if necessary, it cannot be done on an *ad hoc* basis without appearing flagrantly unfair, not to mention causing tremendous acrimony within the group. A typical method is unanimous vote of the remaining partners. Any method of elimination also should be explicit regarding whether the excluded individual's interest in the group must be bought out, and for what amount.

6. **Benefits:** Although there are some advantages to having each member be responsible for his own benefits, many groups have a fixed benefit package that may include participation in some form of tax-deferred compensation plan. If this is the case, the vesting period should be determined. Many plans are not fully vested for ten years. A physician leaving before the vesting period may forfeit some contributions made on his behalf.
7. **Workload:** It is frequently helpful to fix minimum (or maximum) monthly hours in the contract. If the group staffs several facilities producing different incomes, shifts should either be distributed equitably among the high and low income slots, or the specific distribution should be specified. Although it seems mundane, the method of scheduling should be clearly established (not necessarily in the contract).
8. **Noncompete Clauses:** Noncompete clauses prohibiting the physician from opening a practice in the same locality without the prior consent of the group, or prohibit the physician from working at or contracting with the same hospital in the event the group loses its contract, are common. Most of these clauses are questionable when challenged, but they should be avoided unless the physician feels he has the resources and time to fight it out in court. The AMA Council on Ethics has long held the position that any agreements that restrict the ability of a physician to practice in a certain area are undesirable because they are "not in the public interest."

Many hospitals prohibit the emergency physicians from opening a competing practice in the same locality. This is done to prevent the ED group from operating its own free standing emergency center which would take patients away from hospital. may want to operate an. Groups should be especially careful about agreeing to such a constraint unless the hospital is not willing to be bound in the same manner. Believe it or not, some hospitals have opened an FEC across the street from the ED.

9. **Liability Insurance:** Responsibility for liability insurance coverage and minimum for same should be established in the contract. In addition, the type of coverage to be provided should be specified. There are two basic flavors of malpractice coverage: occurrence and claims-made. Occurrence policies cover the practitioner for any suit that originates from an event that *occurred* in the covered period. Claims-made policies, on the other hand, cover the practitioner only for *claims* that are *made* in the policy period.

For example, an occurrence policy in effect in 1990 will still cover a physician for a suit brought in 1997 that stems from an event in 1990, even though the physician may no longer be insured by that carrier. A claims made policy in 1990 will not cover a suit brought in 1997, because the claim was not made in 1990. Because of this, occurrence policies are considerably more expensive than claims-made policies.

The difference is lessened by the fact that claims-made coverage concludes at the end of the coverage period. To retain protection indefinitely after the coverage period ends, a so-called "tail" or prior-acts coverage must be purchased, usually for a period of two years. If a contract provides claims made coverage, then it is important for it to identify who is responsible for maintaining the "tail" should the physician leave the group.

10. **Indemnification and Hold Harmless Clauses:** Many group contracts contain indemnification and hold harmless clauses. Within the group, these are sometimes reasonable. However, between the group and the hospital, they can be problematic and in some circumstances they can void your malpractice insurance. Hold harmless clauses essentially say that in the event of a suit, neither the physician nor the group (or hospital, as the case may be) will sue the other party to recover any damage judgment. In other words, they will hold one another harmless in this regard. An indemnification clause says that if a suit arises, and the hospital, for example, is found liable, the physician will repay the hospital the damages it suffers.

The legitimate aim of these clauses is to prevent a group of defendants from pointing fingers at each other, or all ganging up on one party to try to escape judgment themselves. The illegitimate aim is to protect the hospital's or group's carrier at the expense of the physician's.

11. **Amendments:** It is desirable to state explicitly that any part of the contract can be amended at any time by the mutual agreement of the parties without affecting the general terms of the contract. These clauses usually also explain each party's rights if the contract is breached. Good negotiation should prevent either side ever having to enforce a breach of contract.

12. **Contract Terms:** Finally, the term of the contract should be agreed upon. It is in the physician's interest to have as long a term as possible. It is difficult to induce a highly qualified physician, who can be expected to have other offers, to move a considerable distance for a position that could vanish in a year or less. New groups frequently find that they must agree to a short contract initially as a try-out. It is best to try for a longer term contract (four or more years) with a one-time-only option to cancel or renegotiate after the first year, and with a termination payment to compensate the physicians if the contract is canceled after the first year. Contracts should be made self-renewing, i.e., they should renew automatically for another full term unless notice is specifically given several months in advance. More than one group has finessed a renegotiation because the contract automatically renewed itself.

In general, emergency physicians have the most leverage in their initial negotiation with a group because they usually are considering other offers. This makes it much easier to turn down a less than ideal agreement.

Conversely, the hospital or group usually has the upper hand in renegotiations. It is therefore imperative that your first negotiation be successful in both getting what you need to develop a high-quality, stable group, and in establishing a basis of trust, cooperation and respect from which to operate in any future negotiations. However, keep in mind that an impressive victory in the initial contract that causes someone to lose face can come back to haunt you when it is time for contract renewal. Most of all, be sensitive to all concerned and reflect the standards of your profession.

## Chapter VI The Final Decision

by Kelly Gray-Eurom, MD

The job search is over. You have determined your family's needs. You have chosen a location. You know the emergency department size and group type that you desire. All the prospecting, planning and preparation allowed you maximum success at your interviews. Your list of questions about the emergency department, hospital staff and group dynamics was answered to your satisfaction. You negotiated through your contract specifics, malpractice insurance, and retirement planning. You have the complete job offer in front of you. Hopefully, you have more than one. The decision to sign or not to sign is now the question.

This is the first time in your career that you have been faced with a choice like this. Medical school and residency both represented finite periods of time to be completed along the path to becoming a board-certified emergency medicine physician. You were not looking for long term career placement, job stability or financial security when you signed your contracts for medical school and residency.

Your power of choice about the programs you contracted with also was severely limited. A panel of professors decided which medical school you attended. A national computer matched you with your residency program. You had input into these decisions, but the final choice had previously belonged to someone else. This time the choice is completely up to you. You may feel ecstatic. You may feel the weight of the world upon your shoulders as you put pen to paper. But, before you sign, finalize your decision making process.

Discuss the entire package with significant family members. They will add the personal perspective you need for balance in your decision making process. Trust their gut instincts, as well as your own gestalt about the group you will be practicing with. Do you like the group? Are they easy to work with? Are they supportive of each other? You will probably spend more waking hours with these people than you will with your family, so this is an important consideration.

Utilize your faculty to provide you with the information circulating on the attending grapevine. Our community of physicians is surprisingly small. You can almost always find an attending who knows the inside scoop. Talk with them about the pros and cons of each job. Senior faculty members have the wisdom of experience. Many academic attendings have previously practiced in the private sector. Many are personally familiar with members of your prospective group. Most know the national reputation of the larger practices. Junior faculty members have access to the younger network of physicians who have goals and aspirations closer to your own. Practice opportunities and standards continually change, so this group of physicians will have the most current information on the job market.

Call former graduates practicing in the geographic area you are considering. Your residency coordinator or director has a list of all the prior graduates and their last known place of practice. Due to hospital credentialing procedures, most graduates contact their residency program every few years for "proof I did this" letters. Talk to them. Find out the local perspective. They may



know information about the group or hospital that is unavailable to anyone else. And they will probably be brutally honest.

Take a weekend to revisit the community. Bring your family with you. You can use the vacation from residency and it is an excellent opportunity to get a second look. Talk to cab drivers, hotel clerks and city employees about the hospital and the community. It is also an opportune time to revisit the emergency department. You were not the only one trying to make a good impression on the day of your interview. Observe the normal operating procedures in the emergency department when the group is not interviewing candidates. Although most departments try to give you an accurate picture of daily practice when you interview, it is always wise to confirm this for yourself. If the group was honest with you about their practice, they will be thrilled you showed the interest to come back.

Do not let salary be the sole, driving factor in your decision to sign a contract. Consider all the important factors, which went into the search process. These factors will be different for everyone, but don't forget them. They are the reasons you got to this final decision making point in the first place, and they will play a large role in your long term satisfaction as an emergency medicine physician.

However, avoid being shy about expecting a comparable salary for the area in which you will be practicing. In order to make a decision about reimbursement, ask other physicians in the region and within the group about regional starting salaries. This is another area in which to utilize previous residency graduates and junior faculty. You should have already pursued this information prior to negotiating your contract, but if you have not done so, do so now.

Never sign a contract until your own legal council has reviewed it. Most contracts have a confusing array of legal speak intermixed with a few paragraphs of understandable English. However, even if you understand every word, have your lawyer approve it. Many contracts still contain non-compete clauses and limits to profit sharing. You are entering into the largest financial and medical-legal decision of your life. If you fail to take the time to safeguard and understand your future, no one else will.

Once you have considered these factors, you are ready to sign your contract. Chose the one that is best for you. Your reasons will be your own, but your reasoning process will be simplified and streamlined.

## Chapter VII Tying Up Loose Ends

by Arlen R. Stauffer, MD, MBA

Each of the 50 states differs to some degree in their requirements for physician licensure. Some of the differences in these requirements depend on whether a physician originates from an allopathic or an osteopathic school, and whether the physician has graduated from an American or foreign institution.

It is important to begin the licensure process well before a valid license actually will be required for work. The necessary paperwork may consume weeks of time, and the documentation (of medical school graduation, etc.) sometimes involves several more weeks. The state Boards of Medicine may only meet a few times a year in some states, so not having all required paperwork and documentation by the time of a scheduled meeting may delay licensure additional months until the Board reconvenes.

Following are the basic requirements for the state of Florida, and these are quite similar to most other states:

1. For allopathic physicians who graduate from an American institution:
  - a. Graduation from an approved allopathic medical school;
  - b. One year of post-graduate, ACGME-approved training;
  - c. Successful completion of the required National Board Exam.
2. For allopathic physicians who graduate from a foreign medical school:
  - a. Graduation from the foreign school;
  - b. A valid standard ECFMG certificate;
  - c. Three years of post-graduate, ACGME-approved training.
3. For osteopathic physicians (there are no foreign graduates):
  - a. Graduation from an approved osteopathic medical school;
  - b. Successful completion of all three parts of the National Board Exam;
  - c. Completion of an AOA internship (or one approved by the Board).

**Key Point:** Plan ahead! Since the time required for obtaining a license varies among different states, start early – it could take up to several months.

### CME

Keep in mind that each state has specific CME requirements. For example, the current requirement for *initial Florida licensure of physicians* is three credit hours of AMA Category 1 continuing medical education in HIV/AIDS and one credit hour of AMA Category 1 continuing

medical education in Domestic Violence. **One hour of Risk Management is required for MDs in their initial licensure period.**

### **DEA Requirements**

In order to prescribe controlled substances, each physician must possess a valid "Controlled Substance Registration Certificate" from the Drug Enforcement Administration, and thus have a unique "DEA number." This requires a valid license and the lack of a significant criminal record, particularly any record associated with drug/narcotic violations. A recent renewal fee for this certificate was \$210. At the time of this writing, there was no information available regarding the length of time required to obtain the initial certificate for a new physician. Again, plan ahead, and do your paperwork early.

### **Hospital Privileges**

The issues regarding hospital privileges are evolving and interesting. All hospitals require a valid medical license from the state in which the facility is located, and nearly all require some post-graduate training.

Although hospitals in some rural areas may not require specialty board eligibility or certification at this time, such facilities are rare. It should be assumed that board eligibility/certification will be required in the future at all hospitals, i.e., applicants for hospital privileges must have documentation of either certification by the specialty board, or of completion of an approved residency program in order to become eligible to sit for the board exam. Certain hospitals may require board *certification* within a specified period of years after privileges are granted (or face suspension of said privileges).

Emergency medicine is somewhat unique because many physicians currently practice emergency medicine having had residency training or board certification in other specialties. While some hospitals specify that a physician's specialty boards must be from the specialty in which the physician plans to practice, other hospitals simply require "appropriate" certification. Of course, using board certification as a sole criteria for granting hospital privileges is not allowed by HCFA and the Federal government

One other issue regarding certification stems from the fact that there is more than one certifying body for emergency physicians. Some hospitals specify which board's certification is necessary, e.g., ABEM, while others do not differentiate between the boards.

It should be noted that the American Medical Association currently is pursuing establishment of a new system that will evaluate physicians based on competence, defined as including evaluation of a physician's basic credentials, subscription to the AMA Code of Ethics, evidence of participation in continuing medical education, and participation in a satisfactory review process. The AMA's "American Medical Accreditation Program (AMAP)" will seek to meet standards acceptable to hospitals, managed care organizations, and other organizations that appoint or contract with physicians. Just what role the AMAP will play in the future of hospital privileging is unclear at this time.

Limitations on the types of hospital privileges for emergency physicians vary considerably. While many hospitals categorize their emergency physicians as "Active (or Attending) Staff" – like physicians from all other specialties within the hospital – some persist in using a special category for emergency physicians such as consultant staff. Such categorization may result in the inability to serve on hospital committees and to vote in medical staff decisions or hold medical staff offices. In addition, special categories negatively impact the job security inherent in being a "regular medical staff" physician and reinforce the image of emergency physicians as being transients.

When applying for hospital privileges, several items of documentation will be required, including documentation of graduation from medical school, completion of post-graduate training, possession of a valid DEA certificate, coverage by appropriate liability insurance, provision for a specified number of favorable references, review of a satisfactory report from the National Practitioner Databank, and proof of appropriate skill levels (perhaps by requiring a print-out of various procedures completed during training). Some hospitals require a personal appearance before the members of the hospital's Credentials Committee before granting any privileges.

Following is a summary of key points related to hospital privileges:

1. The availability and breadth of hospital privileges varies considerably for emergency physicians;
2. One should assume that specialty board eligibility/certification of some type will be required at every hospital in the future in order to obtain privileges, although this could be modified by the AMA's AMAP process;
3. There are varying levels of staff membership for emergency physicians at different hospitals. This may play a large role in determining the available levels of involvement in staff issues for the physician, and the consequent degree of job security/stability that exists at that hospital's Emergency Department;
4. Numerous items of documentation will be required with the application for privileges at any hospital.

### **An Updated Procedure Print-Out**

Nearly all residencies possess a mechanism for documenting procedures completed by the resident physician during training. As noted previously, such a list may be crucial for obtaining privileges at some hospitals today. An accurate, updated print-out will likely become a necessary part of the application process for hospital privileges in the future, and perhaps for accreditation via the AMA's AMAP process. Such a print-out also allows the emergency physician to assess his/her own experience.

### **State Chapters of ACEP**

Opportunity for involvement in organized emergency medicine begins with the state chapters of the American College of Emergency Physicians.

Membership in a state chapter requires membership within the national organization, and policies and organizational structure of state chapters are influenced and/or controlled to some

extent by the national ACEP. Such policies often are reviewed and/or modified within the ACEP Council (at the Annual Council Meeting, where each state chapter has opportunity for input and debate on the issues).

### **Medical Society Involvement**

Most counties have medical societies which are tied to its state association and to the American Medical Association. Involvement in organized medicine as a whole allows a physician to gain access to the policy-makers, and to have the opportunity to influence such policy.

**Chapter VIII**  
**The First Year in Practice**  
**or "Why didn't they tell me it would be like this?"**

by John L. Meade, MD, FACEP

During your emergency medicine residency, you are trying very hard to master our field, which is so broad and virtually all encompassing. A few of you will stay in the academic world, and teach those coming behind about the science of emergency medicine. For those who become full-time academic faculty, the biggest change in your practice (aside from the larger paycheck!) will be the heavy responsibility of being an attending. These colleagues must refine their abilities to supervise without being too intrusive, and learn to coax the best out of different personalities. They must make sure they stay current on the subject matter, so residents get the best possible information. These emergency physicians are moving up a rung on the academic ladder that they have spent at least the past eleven years climbing.

However, most emergency physicians do not stay in the academic setting, taking instead positions in hospitals across the country. Obviously, there are far more of these positions available, and often they offer a higher salary than academic jobs, but the responsibilities are quite different.

Can you play well with others?

The new kid on the block has much to learn, and should try very hard to do so. Mastering the art of medicine is as important as mastering the science of medicine. When you join a group, you may find yourself working with people whose style of practice may be very different from your own. They may not order tests that you think are routine, or may do many more radiographs than you think are required.

Before assuming your new partners are incompetent, determine why these different practice patterns exist. There may be important reasons why things are done a certain way in your new setting. State laws vary, as do hospital policies. Learn, before you complain. At your monthly group meetings, start a Journal Club, to allow everyone the opportunity to discuss the cutting edge of our field, and share various ways of doing things. You may even be able to start an area-wide Emergency Medicine Journal Club, which will enable you to learn from your colleagues at neighboring hospitals.

If you feel the group practice needs improvement, volunteer to spearhead a project to deal with it. This might include writing new discharge instruction sheets, doing an inservice for the nursing staff on chest tube insertion, or working with the hospital public relations department on creating a public service announcement. Make sure you get consensus from the rest of the group, so it does not appear that you are criticizing established policies or procedures.

Some issues that appear more mundane can be important for the success of a group. For example, get to work on time so your partner can be relieved. If you must turn over a patient, document your history and physical up to the point of the turnover, and be clear in the

documentation at what time you signed the patient's care over to your colleague. Let the patient know someone else will be taking over, but reassure him/her that you will tell the new doctor all about their case.

Nothing causes more discontent in an Emergency Medicine group than the feeling that some are working harder than others. In a fee-for-service situation, those seeing more or sicker patients usually are paid more. However, in a straight hourly fee payment situation, any physician who shirks the unpleasant cases, or sees too few patients per hour, is sure to cause ill will with the rest of the group. Some groups deal with this by having some sort of "performance factor" built into the payment scheme. Others monitor the numbers and types of cases seen by the physicians, and give feedback to anyone who is not carrying his share of the load. Thus, it is always important to carry your fair share of the load. Most important, make certain your group has addressed this issue if applicable.

### **Getting Along with Nursing/Ancillary Staff**

A savvy emergency physician will say little and listen a lot when starting a new position. Everyone will scrutinize the "new guy," and whatever he does will be analyzed and critiqued by one and all. Ask lots of questions, and try to learn as much about your new facility as you can. The nursing staff, along with respiratory therapists and other ancillary staff, will quickly determine if the new physician is someone with whom they want to work. If they like you, your life will be much easier.

Anytime a new emergency physician starts to work in an ED, he brings with him certain methods, preferences and procedures that may be new to the staff. There is sure to be resistance from the nursing and ancillary staff regarding any change. Change means people must learn something new, and carries a message that the previous method was wrong.

Resist the temptation to tell people about how wonderful things were at your prior institution. In fact, you should step back and learn how and why things are being done at the new hospital. Perhaps there are some institutional idiosyncrasies that make their way of doing things work better. Remember, that most new emergency physicians are not brought in fresh from residency to change an ED. Only after you have been in the new job for a while will you be in a position to effect changes that may be helpful. Moreover, such changes should be carefully thought out.

### **Getting Along With the Medical Staff**

Emergency medicine group directors will say that people finishing an EM residency are expected to be excellent clinicians. That is now considered baseline and should be a source of great pride to our specialty and its residency programs. However, this shifts the focus to personality. Social skills do matter and unfortunately are not taught in most residency programs.

In a teaching hospital, once the EM resident is ready to make a disposition on the patient, he usually runs it past the attending emergency physician. If a decision to admit the patient is made, a resident from another specialty is called down to the emergency department, and told to admit the patient. They will rarely argue, although they may moan and groan about the extra work. The hierarchy is such that they know it is unlikely they will get out of admitting the patient, so they just do it. The EM resident then goes on to the next case.

In the "real world," situations are often very different. As the attending emergency physician, you must call another attending physician in another specialty to have the patient admitted. Some physicians will call back almost immediately, and others will call only after numerous voice pages. If the latter is the case, resist the temptation to start the conversation with irritation in your voice. Remember that few on the medical staff ever want to get a call from the emergency department! Even your friends on the staff do not want to hear from you during your shift. Your call means only one thing—more work for them. Try to remember what it was like when you were a resident on another service and how you disliked hearing from your fellow EM colleagues. Instead, go out of your way to be pleasant with the other doctors. It helps ease the sting they feel and will make them more agreeable in assisting with the patient.

At the outset, tell the other doctor why you are calling, and what you expect from him. As a student, and perhaps even as a junior resident, your patient presentations were long, sometimes rambling, and very detailed. You did not want to take a chance of leaving out something that was important, so everything was included. Just as you learned to take a focused history and physical examination, you must learn to make a focused presentation of patients to other physicians.

For example, after a few pleasantries, you could say "I have a patient here tonight with chest pain who needs to be admitted. She is a 54 year-old black woman, hypertensive, and diabetic, who smokes two packs a day. Her chest pain started about three hours prior to arrival, and was relieved after two sublingual nitroglycerines in the ambulance. Her ECG and chest X-ray are normal, and the labs are pending." Very few physicians would argue that this patient should go home. By presenting the case this way, you have informed the doctor of all the important details, and he knows you have the situation under control. He now understands that he does not necessarily have to drop everything and come see the patient in the ICU. He is then able to ask for whatever further data he needs, and you have not bored him with needless information. You have effectively set the ground rules for the discussion, without being overbearing. The rest of the conversation is just details.

Some physicians will disagree with your decision that a patient needs admission. If they are familiar with that particular patient and have important background information to share, listen with an open mind. You will find that their additional knowledge is valuable and may sway you to agree with an outpatient plan for the patient. If, in spite of that, you feel strongly that a patient should be admitted, stand your ground. You are the physician of record for the patient on that presentation and responsible for the disposition.

In some instances you could find yourself at an impasse, and the only action left is to inform the other doctor that you will not discharge the patient. Although you do not want a reputation of being disagreeable, you always must do what is best for the patient. Be certain within yourself that you are doing what is best for the patient if such a standoff is necessary. If you are not sure, or the political ramifications are likely to be high, contact your ED director and discuss it with him before drawing up battle plans. These kinds of confrontations are costly in terms of good will and should be avoided whenever possible.

Modern emergency medicine is a specialty on par with every other specialty. If we are to receive the respect that other physicians get, we must earn that respect by paying the dues to join the club. We must not be faceless voices on the telephone bearing bad news in the middle of the



night. Get to know the rest of your staff informally and do whatever it takes to be considered a fellow member of the staff, not an intern or the house doctor.

Due to the nature of our practice, we are often in the hospital at hours counter to the rest of the medical staff. We may never have time to dine with colleagues or do any of those other things that allow physicians to get to know each other and create some sort of relationship. Thus, it is up to you to create those occasions! Join the county medical society, and let the other doctors see you at meetings in a pleasant environment. Invite some of them to play golf or tennis with you. Serve on a hospital committee. Make presentations to local specialty groups on emergency medicine or some other issue. Go out of your way to help eliminate the stigma of the "ER doc" as an itinerant worker, who is never a real member of the medical community.

### **Getting Along With Administration**

The first thing to know about dealing with hospital administration is that generally they do not have a medical background. They are business people, and any discussions you have with them must take this into consideration. Additionally, physicians are trained to do what is best for a single given patient, regardless of the cost. Administrators are concerned with the ongoing health of the hospital. Both approaches are valid and necessary for the continued delivery of health care in your community. However, these differing mindsets are bound to come into conflict at some point. For example, no protests about quality of care will stand against an administrator who says, "We cannot afford it."

The best approach is for you to learn more about the hospital's long term goals and plans, and show the administration how your group can help the hospital achieve those goals. That may mean diversification of your group into new areas, such as observation units, walk-in clinics, occupational medicine, and others. Such diversification, if done well, can create additional jobs for your group and consolidate your positions. Older members of the EM group, or those with physical limitations may find such areas a great pathway to continued employment with less stress or fewer night shifts.

Another aspect of management emergency physicians must accept is that, as far as the Administration is concerned, no news is good news. Patient or staff complaints about you are taken seriously. Even if the complaint is without merit, it is time-consuming and stressful for the administrator to handle. If several such complaints are filed against you, he will start to believe that "where there is smoke, there is fire." A busy ED may see 60,000 patients per year, while employing 10 full-time emergency physicians. That means each physician should see 6,000 patients per year. If you made 99.9% of the patients very happy with their care, that could still result in six complaints per doctor per year. You can rest assured that no administrator wants to hear about the same physician every other month, and certainly does not want to hear five complaints a month for the group. Make sure that complaints are referred back to the ED Director, or perhaps the emergency physician assigned to quality assurance issues. Whenever possible, the complaints should be handled internally rather than by administration.

Just as you must work to make yourself an integral part of the hospital medical staff by joining committees and getting to know your fellow physicians socially, you also must become involved in community activities. You should be appointed to the Boards of the local chapter of the American Red Cross or Cancer Society. Be active in your church and the United way. Be seen

frequently on television as a local medical expert. Not only will your life be enriched, but your hospital administration may view you as a fixture in the community. Other specialists have understood this for years. It is time for emergency physicians to do likewise.

### **Getting Along With Patients**

Most physicians think they are holistic in their approach to patients and believe they are doing everything within their power to make every patient encounter warm and pleasant. The truth is most of us do these things very poorly. We have had very few role models and we all know of occasions where patients were depersonalized or treated rudely.

Most patients have a family doctor office visit in mind as a reference point for interactions with physicians. Unfortunately, a busy emergency department is about the farthest from this reference point that you can get. The patient is often very sick, hurt and/or scared, and his family may be just as frightened. The patient is brought in, asked to undress in a cold, noisy area, with often just a flimsy curtain to protect privacy. He must put on a gown that is sure to remove his last shred of dignity. Then the patient must sit and listen to crying, screaming, and profanity while waiting interminably to be seen. He hears everything the patient in the next cubicle says and knows others will be listening to him. Finally, someone he does not know comes rushing in asking him to quickly explain why he is in the ED. The person is assumed to be a doctor, although his self-introduction was so fast that the patient did not catch the name. This "ER doc" asks rapid-fire questions, barely letting one get answered before spitting out the next and interrupts if the answers are not heading in the desired direction. After less than five minutes, he abruptly leaves, then someone new comes in to draw blood. Ninety minutes later, a nurse comes in with a prescription and the patient is ushered out.

Is it any surprise that patients are dissatisfied with the kind of care they get in emergency departments? Patients deserve better. We were taught the First Rule of Medicine: "First, do no harm." I propose the Golden Rule is just as important: "Do unto others, as you would have them do unto you." If you or your loved one was a patient in an emergency department, you would want to be treated with respect and dignity. You would expect attention from calm, caring nurses and doctors, and informed of everything that was done. For example, a simple statement that blood tests will take about an hour will do much to decrease the anxiety in the patient. At the time of disposition, the patient deserves to have the emergency physician come back in to discuss the findings and answer any questions the patient may have. Anything less than that, and you will find yourself with unhappy patients. You may have given the patient excellent care on paper, but to the patient the experience was unnecessarily negative. Studies have shown that what is most important to patients is the sense that they were cared about, not necessarily that they received excellent care. We must constantly strive to put ourselves in the patient's position, and do what is best for him, not necessarily what is most expedient for us.

### **Conclusion**

In the first year of your practice of emergency medicine, be aware that you will be thrust into situations where people are watching your every move, while they perform in ways that are new to you. The way you practice will be questioned. You will have to prove yourself trustworthy to doctors who do not know you, and you must learn to trust them as well. You will have to learn to

express to patients that you truly care for them and their concerns, even in a rushed and hectic environment.

The first year in practice will be a trying time and extremely exciting and rewarding. You are finally a full-fledged emergency physician. Embrace the joy that comes with the healing arts and enjoy the special role you play in being part of the greatest profession on earth.

## Conclusion

by Kelly Gray-Eurom, MD

Drs. Campbell and Zappa gave you an overview of the job search process. They provided you with elements to consider when beginning your search, including a detailed format for comparing adjusted salary rates, and an explanation of the type of physician groups available. They also provided information which you should obtain about any group you are considering. In addition they offered you a place to start the overall search for employment.

"Prospecting and Interview Planning" by Drs. Gray-Eurom and Perry provided you with the meat and potatoes of the search process. This chapter stressed the importance of understanding the interview process as a business venture. The rules and expectations of the business culture were highlighted. Emphasis was placed on knowing your own needs as an emergency medicine physician, finding the resources you require, and understanding the preparation you must do prior to the interview itself.

Drs. Kang and Fisher simply and concisely explained the interview day itself. Although the information was straightforward, the importance of its content can not be over emphasized.

Dr. Perry then gave you the experienced emergency physician's perspective on all the questions you should ask on interview day. These questions were not generated at random. They came from her "If I had only known this" file. These items are the ones that will plague you at two in the morning when no administrator is around. Be smart and find out about these issues ahead of time.

The contract section was prepared by Dr. Robert Wears, who teaches physicians how to negotiate and understand the financial aspects of emergency medicine. The details in this chapter provided the framework to empower you to negotiate your own contract. Read and re-read this information. Then save it.

Finalizing your decision-making process was the topic discussed in "The Final Decision". Useful resources were given to help simplify the decision making process. The importance of utilizing a lawyer to review your contract prior to signature was highly recommended.

Dr. Stauffer offered you key details to consider once you have accepted a position. Not completing state licensing requirements, DEA paperwork and hospital credentialing can lead to a delay in your start date and a delay in that first paycheck. He also provided you with the information you will need to actually begin your new job.

Finally, Dr. Meade gave you his personal insights into the first year out of residency. This may appear to represent one person's impressions, but pay heed to the message. His words accurately reflect the personal skills you will need to succeed.

And so we reach the conclusion of this publication. For our part, we have done our best to compile an overview of the strategies we have found useful in our careers as emergency

medicine physicians in the professional sector. We have shared our combined experiences in an effort to help you succeed as you enter the business world of emergency medicine.

We wish you well and look forward to seeing you around the ED.