

Considering the Physician Workforce

In 2006, even before the current financial crisis, the Association of American Medical Colleges (AAMC) was concerned enough about a projected physician shortage that it called for a 30 percent increase in medical school enrollment. Last November, in a report called *The Complexities of Physician Supply and Demand: Projections Through 2025*, the AAMC restated the points it had raised over the last few years: a physician shortage already exists in parts of the country; almost one in three doctors in practice is 55 years old or older and likely to retire over the next 20 years; a growing population “may drive demand sharply upward for specialties that predominantly serve the elderly.” The report also mentions “mounting evidence of place- and specialty-specific shortages across the U.S.,” which I find one of the most persuasive observations. The physician supply is a longstanding issue, but as the nation considers reforming the health-care system, the topic has new urgency.

Based on current trends, the report posits a shortage between 124,000 and 159,300 FTE physicians by 2025. Either figure is challenging for the schools that prepare our future doctors. Still, as the word *complexities* suggests, such projections are not only complicated but open to debate. As the report states, “There is much work to be done to better understand the dynamics of the physician workforce.”

One important factor that influences career choices is the escalating cost of attending medical school. According to last year’s AAMC’s Graduate Questionnaire, students had an average debt load of more than \$140,000, and 17.7 percent of graduates carried educational loans of \$200,000 or more (*AAMC Reporter*, December 2008). Some experts argue that debt strongly influences which specialties new graduates select, often to the detriment of lower-paying specialties in primary care, and that the cost of medical school may limit underrepresented in medicine students from applying.



The Journal of the American Medical Association has also looked at factors influencing career choices. “Structural changes to the curriculum to facilitate more primary-care experiences promoted student interest in primary care, but [projected] income, debt, and work hours dissuaded students from this path. . . . Students increasingly prioritize life-style issues when choosing careers” (September 10, 2008). Based on my experiences at Penn Medicine and elsewhere, however, I believe most students still uphold the altruistic ideals of the profession. Every year, at numerous events involving our students, it is refreshingly clear that they retain a powerful civic impulse.

As leaders of our medical schools continue to monitor the physician workforce, we look to organizations like the AAMC and the Association of Academic Health Centers to help us. At Penn, we are fortunate to have one of the most respected experts on this issue in Richard A. Cooper, M.D. Dr. Cooper spent many years here, then served as dean and executive vice president at the Medical College of Wisconsin. He returned to Penn in 2005 as a professor of medicine and a senior fellow in the Leonard Davis Institute of Health Economics. He has studied the physician and nurse workforce for many years, and numerous articles acknowledge his work. Today, he is also co-chair of the Council on Physician and Nurse Supply, with Linda H. Aiken, Ph.D., R.N., the distinguished Penn professor of nursing and of sociology.

In May, Dr. Cooper testified before the United States Senate Committee on Health, Education, Labor, and Pensions. Any effort to reform the nation’s health-care system, he said, must deal with worsening shortages of physicians. The

fundamental problem, as he put it bluntly, is “too few physicians to serve the needs of the nation.” As he has in the past, he argued for expanding the number of medical students and, even more important, expanding residency programs. He also urged “innovative practice arrangements” among physicians, hospitals, and nonphysician clinician providers.

Even if the projections about the physician workforce are only partially correct, how should a school like ours respond? For a start, provide more financial aid. In 2005, we awarded \$4.9 million in financial aid to some 250 students – about a third of the total number of students enrolled in any one year. We want to do much more, which is why we set a goal of raising \$100 million for student financial aid, as part of Making History: The Campaign for Penn. Our most recent count was \$24 million raised. That’s very impressive, but we hope to reach our ambitious goal.

Our school regularly places in the top five among what *U.S. News & World Report* calls “research-oriented” medical schools. On the other hand, our school is also ranked – with less fanfare – among the schools more oriented toward primary care. In the last few years, our school has been ranked higher on that survey as well. In 2004, it was 46th, but this year it was 12th. Even in the research-oriented survey, Penn consistently ranks very high in internal medicine. In short, our excellent students have a wide range of career options before them.

We look to professional organizations and experts like Dr. Cooper to help us shape our policies on the physician workforce. At this point, we do not believe Penn Medicine should increase the size of its classes. Our goal is to continue to produce the future leaders of the profession, and it is in fulfilling that role that we believe we can serve the nation best. ■

Arthur H. Rubenstein, M.B., B.Ch.
Executive Vice President of the University of Pennsylvania for the Health System;
Dean, School of Medicine