AMA

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AMA

AMA Moving Medicine

Doctor shortages are here— time to act, Drs. Harmon and Orlowski weigh in

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Featured topic and speakers

Two of America's most influential physician voices, AMA President Gerald E. Harmon, MD, and Janis M. Orlowski, MD, the AAMC's chief health care officer—detail what's driving the physician shortage, how the pandemic's exacerbating it and how it can be overcome.

Speakers

- Gerald E. Harmon, MD, president, AMA
- Janis M. Orlowski, MD, chief health care officer for the Association of American Medical Colleges

Host

- Todd Unger, chief experience officer, American Medical Association

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Transcript

Unger: In 2021, the Association of American Medical Colleges, or AAMC, released a report indicating a grim physician shortage in our nation's future. AAMC anticipates a shortage—within a dozen years—of up to one hundred twenty-four thousand physicians.

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AMA

In this episode of Moving Medicine, AMA President Dr. Gerald Harmon is joined by Dr. Janis Orlowski, chief health care officer at the AAMC. They discuss the complexities of the report, what's driving these trends as well as possible pathways for solutions.

Here's Dr. Harmon.

Dr. Harmon: Thank you, Todd. Hello and welcome to AMA Moving Medicine. Today, I'm joined by Dr. Janis Orlowski, chief health officer at the Association of American Medical Colleges to discuss the continuing trends that show we're headed for a significant physician shortage in the years ahead, what it means for medicine and for our health care system, and what can be done to address it. Welcome, Janis. It's a real pleasure to speak with you today.

Dr. Orlowski: Thank you very much, Dr. Harmon. Thanks for having me and thank you to the AMA. Look forward to our conversation.

Dr. Harmon: Dr. Orlowski, AAMC's report from last June, the complexities of physician supply and demand, it really paints a pretty grim picture of the future of American health care with a physician shortage of up to 124,000 by 2034, just 12 short years away. What does the AAMC research say is driving this shortage?

Dr. Orlowski: Well, you're right. We are concerned about it and that is why we are trying to address the issue. The main two factors that are affecting this are, first of all, the growth in the U.S. population. So, we are using U.S. Census numbers. We see the growth in the U.S. population and that's a big factor. And number two, right behind it is the aging of the population. So, we really have the baby boom. They're in their sixties to seventies, maybe a decade plus or minus on either side. And we know that individuals consume more health care after the age of 60. So, we've got a very big generation that is moving over the age of 60. Those are the two biggest factors.

Dr. Harmon: I have to ask what concerns you the most about these findings? How might patients experience this physician shortage if it's not solved? And how would the entire health care system experience it? I know those are broad ranging questions but I'm interested in the crystal ball that you might have to give us some insight into this.

Dr. Orlowski: Well, we talk about a worsening physician shortage but I want to make sure that people understand that there's a physician shortage today. And we actually work and utilize the federal government's numbers that come out of HRSA, which say that there is a shortage right now. They have a defined both the primary shortage as well as a behavioral health, a psychiatry shortage.

But I think the way that it will manifest is that people will have increasing difficulty accessing health care and accessing physicians. That's what we're going to see. And I know that you probably anecdotally have heard the story where someone needed to see a specialist and it took six weeks or

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eight weeks to see a cardiologist or a G.I. specialist or whatever. And I think that access is going to continue to be more and more difficult.

Dr. Harmon: You know, and I'll tell you anecdotally as a family medicine specialist myself, I find that those issues as you indicate, they're present with me now. So, I have to manage the expectations of my patients and my personal expectations when I make referrals to various specialists, just because they're not as geographically close and there are not as many as I need for the particular urgency of the situation. It is quite a challenge.

Now the AAMC has really similar reports over the many years. And how are perhaps the factors today driving these trends any different than they might have been a generation ago?

Dr. Orlowski: So maybe two or three things that I can point out. First of all, in the early 2000s when the AAMC talked about the fact that we were going to experience a physician shortage, they called for medical schools to increase their number of matriculates, number of students. And so, what we've seen since about the mid-2000s, say 2005 or so, we had maybe about 125 MD-granting medical schools and we're now up to 155. And so, we've seen both an increase in the number of medical schools, as well as a number of medical schools that were present, that were in existence, they've increased their class size.

So, on the MD side, we're actually seeing more than a 35% increase in the number of matriculates, which is great. On the DO side, what we're seeing is an even greater expansion as you take a look at a percentage. Now DOs, they had a smaller number of matriculates but we've seen that they've doubled in size. So, both on the MD, as well as the DO side, we have seen an increase in the number of matriculates. Now it'll get us later into the question of—can everyone get a residency program? And we can talk about that.

But the second thing that I would tell you as we take a look at these numbers is, as we look at them, we are seeing difference in different areas. So let me tell you. In rural America, we are seeing not only a primary care shortage but we're all also seeing a general surgeon shortage. So that's an example. Depending upon where you are in the country, there may be difficulty getting to different specialties. And even though we don't often talk about it, there is a problem also in urban settings. And so, people have difficulty accessing primary care and accessing specialty care. And that's probably a combination of insufficient number of physicians but also insufficient access to insurance and other factors.

But those are the two things that we see are shifting over the last couple of years. And as you said, we used to do this report every three to five years. Now we're doing it annually because we believe that these are numbers that are important and that we must address.

Dr. Harmon: Thank you, Janis. And you're exactly right. The urgency is now. And I think the AMA has had position statements. The AAMC has been very gracious in supporting our reports and yours. But

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I'm also hearing from colleagues that not only we're not producing enough physicians and in various specialties but we're also having a retention issue. I talk to a lot of my colleagues and they're considering leaving the profession. We've had data from AMA's own polls that show, almost independent of the COVID pandemic, as many as 20% of physicians are planning on leaving the profession within the next 24 months and a substantial number are talking about reducing their access and hours.

There are a couple of reasons that they offer to me. They're burned out, a common thing. They're fatigued both emotionally and physically, and they're overwhelmed with the burden of practicing medicine, just the impediments that we face as practicing physicians every day, the barriers to delivering care in an quality manner from electronic records to prior authorization, to the cost of medications. It's just an ongoing assault on all of us as providers and they're really getting discouraged. What is the AAMC hearing from physicians that you talk with about the reasons they're considering leaving the profession?

Dr. Orlowski: We're hearing exactly what you're hearing. We did a study, which we call the National Sample Survey of Physicians. We do that every couple of years and it becomes a baseline work for our work on the physician workforce. And we are hearing exactly that. Because of the burden, because of the difficulties in continuing to practice, because of well-being issues, people are either leaving the profession or they're cutting back their hours.

Our last national sample survey of physicians was done just a couple of months before the pandemic, in the fall of 2019. And so, we actually are launching right now, a national sample survey to take a look at those numbers immediately after COVID. And we are a little bit anxious about that survey and think that we are going to continue to see worsening of the trends of people leaving.

One other thing that I would point out to you is that in the next five years, 35% of physicians will be of retirement age. And so, we've got, if it's not that people are wanting to cut back their hours in order for well-being or they're frustrated by practice, we're actually just seeing physicians are getting older and getting to the point of retirement. So that number depends because physicians tended to work longer. So, as we take a look at retirement, we might have 20 to 35% of the workforce just leaving because it's that time in their life.

Dr. Harmon: I appreciate that. The pandemic, as you mentioned, and I would be concerned about what our new studies might show as we measure, if we can measure, the impact of the pandemic on our physician workforce. I'll tell you, I rotated with, and up here I actually rotated as an inpatient hospitalist with our teaching service and our family medicine residents here in my small health care system. And in the midst of a surge last fall, just after we had, unfortunately, a bunch of summer exposure to more and more coronavirus patients, we were over overwhelmed in our inpatient system. A lot of my young doctor colleagues, my resident physicians, they're doing heroic work. They were working seven days a week, long hours in the day. And they were doing really good work but all of

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them had a little bit of emotional and even physical weariness.

And they commented to me that they were very proud of their ability to become doctors. And they were very happy about their career choices but they were thinking perhaps that the frontline medicine, the emotional wear and tear was really starting to impact their career decision on specialty choice, practice types. And these are folks that are just beginning their medical career. So, I was real concerned about experiencing, what I would say from my military experience, was battle fatigue. They were having battle fatigue in COVID treatment and COVID response fatigue. Does the AAMC have a perspective? Have you been able to gather any impact of the pandemic on young physicians and even medical students?

Dr. Orlowski: Well, I'll tell you, I'm like you, Dr. Harmon, I rounded this morning and it's very interesting. I've never had so many discussions with other physicians about balance in your life and sort of well-being. And I think you're right. It's this fatigue that we're seeing from what we've all gone through in the pandemic. And I think that people are reevaluating the quality of their life, their profession. And I think that the number one issue right now for us is to take a look at physician well-being and making sure that physicians feel comfortable continuing to practice, that the irritations of practice are minimized.

I know during the last couple of years, we've had many conversations with the administration about decreasing regulation and looking at physician documentation needs. And those have been adjusted. The AMA has been a good partner as we have had these conversations to try to do that. We need to do more of that.

The one other thing that I would tell you that we're seeing is before the pandemic, we noted that if you compare millennial physicians, so physicians who are in their thirties, to physicians who are in their late fifties or sixties, we noticed a slight decrease in the number of hours that they work per week. It wasn't a lot per person. It was probably about four to five hours per week. But if you take four to five hours, times 200,000 physicians, that's a tremendous decrease in access to physicians.

And I think what we're seeing is as people join the profession, that not everyone is going to be willing to work 60, 70, 80 hours a week. I think, and probably for the best, there is this desire to have a balance to your lifestyle. The one ray of sunshine and I have to share this with you because I find it just wonderful to hear. As we took a look at admissions to medical school and people who filled out applications, a year ago during the absolute height of the COVID pandemic, we saw an 18% increase in the number of individuals who applied to medical school.

And I think the message is that they took a look at the work that we and our fellow physicians did and they took a look at the good we were doing to society, and the profession itself. And they said we want to be part of that. So, I think that there's a glimmer of hope as we see the tremendous increase in the number of applicants.

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Dr. Harmon: Well, that is, as you said, and I've had commentary to that effect too. If there are some silver linings to this cloud of the COVID pandemic, telemedicine is one. Innovative opportunities to take care of patients is another. And as you said, a renewed sense of purpose, that we're all looked at and looked at as the health care profession is a real admirable profession. So that may be one of the silver linings.

As we talk solutions, if we can Dr. Orlowski, there are short term and long-term strategies, and we've talked a little bit about asking the administration to reduce the administrative burdens. That's certainly short term but I also think there's some long-term opportunities too. Could you maybe tell us what the AAMC is thinking about as far as strategies that could be effective over the long haul, so that we can ensure we address the problem now but also don't face a similar one in the future?

Dr. Orlowski: So, I would say that our recommendations fall into a couple of areas. First of all, we know that medicine is a team sport right now. And I think what we have to do is continue to educate and continue to build strong teams. And that is a way for physicians to continue to practice at the top of their ability while being able to work with other pharmacists, dieticians, social workers, who are able to take on some responsibility in care of the patient. And I would tell you that one of the things, when I speak with rural America and people who are trying to attract physicians, what I say is try to make sure that you're not just trying to attract a physician but you're bringing together a solid team that can provide care. So, I think that is one thing.

The second thing that we have taken a look at is the different access to physician care. You mentioned telemedicine. I also think that there's other ways that we can be taking a look at how we can help physicians. There is electronic consults. There is electronic referrals. There's asynchronous ways that we can monitor patients. And I think that there's a number of different technology solutions, again, that the physician and his or her team can utilize to improve access, to improve oversight of the physician, without everything having to be a direct physician to patient experience. I know in doing telehealth myself, there are some things that I think are very good about it. And then others that I know it doesn't substitute for a face-to-face visit. But we're learning and teaching about that.

And then finally, as we have increased the number of medical school slots, we are asking the federal government to fund a greater number of residency slots. Medicare for more than 50 years has supported residency training. There is a section of President Biden's bill that recommends increasing the number of slots that are supported by the federal government and we believe that is needed. So, as we increase medical school matriculates, we need to increase the number of residencies that are supported. And I would say those three things—increase the number of residency slots, technology advancement and teamwork that is really integrated with a physician are the things that we can do to try and stave off this crisis.

Dr. Harmon: Thank you, Dr. Orlowski. Both of our organizations along with dozens of others are part of the Graduate Medical Education or GME Advocacy coalition and we've been supporting those type

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of bills in Congress. You've mentioned some of the current activity and you're right. I recall that funding for a thousand new Medicare-supported GME slots has been included in the Consolidated Appropriations Act of 2021 and it calls for up to 200 positions being added annually with the stipulation, however, that no hospital can receive more than 25 new FTE residency positions in total. This is a step in the right direction but I've had public messaging on behalf of the AMA that says this is nowhere near sufficient.

Growth in the number of residency slots has stagnated since the Balanced Budget Act of 1997 and essentially capped the positions at existing programs. And so, the AAMC and AMA and others that are part of the coalition are working very hard to improve access for these several thousand medical school graduates who have to find a graduate medical education opportunity in order to become part of the physician workforce. And that's important.

I wonder. Do you think the other magic answers might include, and we talked about it—can we improve other access opportunities for medical students to practice in rural areas? Do you have some ideas what we might be able to do to encourage physicians to go into these physician shortage areas, like where I live in the rural area of South Carolina?

Dr. Orlowski: Absolutely. So, a year ago, a thousand GME slots were approved. And as you said, a thousand is step in the right direction but hardly substantial enough. So, we've got several thousand more that is in the president's budget right now. And besides those that are just straight up residency slots, the president's budget also includes some slots for people who are underserved, people of color, people who have had difficulty in paying for their education. And so, it's provided support, not just for medical school but also residency. So, there are a couple of different solutions to increase the number of residencies. So that I think is where we need to go. There's no doubt about it.

You mentioned then having clinical spots. As we talk to deans of medical schools, what they say is they are running short of training slots for residents and for medical students. And I think the ability for more people to be mentors and take on an educational role in training physicians is exactly what we needed. What we find is that if a medical student resident is trained, spends part of their training in a rural area, they are more likely to come back to that rural area. We also know that if we accept a medical school kid who graduated from a high school that was in a rural area or if there's family in a rural area.

So, I think we have to be very smart as we take a look at the diversity of the classes that we bring into medical school. So not only what's the gender and what's the diversity in race and ethnicity but what is the diversity that there is in geographic background. All of those factors need to be taken into account as we look at admissions to medical schools.

Dr. Harmon: You're right. And I see that in my rural area. If I get young, future physicians that have grown up in the area that have ties to the area, they're very much inclined to come back, whatever

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special they choose, to practice in that rural area and their community. So, it very much is a fact.

I'll also tell you that the average young doctor graduates with about $200,000 in debt and it tends to drive them to higher payer positions in larger cities and certain specialties. That might contribute to our physician shortage in our rural areas. The AMA and AAMC have both initiatives and efforts to improve that ability to serve that medical school debt and reduce the cost of medical education. And I think that's an important offering we can bring up also.

Dr. Orlowski: Absolutely. What I would tell you is the AAMC's work in this area shows that medical students and residents are attracted to positions, first of all, by strong mentors. And so once again, a pitch to have very strong mentors. If they work with a physician where they see the individual as a wonderful physician, very knowledgeable, helping someone and they can envision themselves in that particular situation, they're more attracted to that specialty. And so, we need strong mentors, particularly strong mentors in primary care. So that's what we see.

I do think that debt burden does continue to play a factor. Our studies show that there are other factors besides just cost but that becomes something that drives people very, very much. And I think that we are looking for primary care practices to continue to help mentor residents and provide clinical spots for residents where people love practicing. There's nothing worse than going to a spot where a physician says, "I'm overworked. I hate this. I want to get out of here." It just completely detracts from the experience. And so, we have to remember how important these clinical rotations are in helping to shape our future workforce.

Dr. Harmon: Dr. Orlowski, one final comment. One of the issues we talked about was improving the diversity of the workforce. When we talk about graduate medical education, the AMA has been urging Congress to provide appropriate funding to support creation and sustainability of medical schools and residency programs that have their roots in educating diverse populations, including historically Black colleges and universities, Hispanic-serving institutions and tribal colleges and universities. And I know the AAMC has a very rich plan and a very well thought out plan on improving health equity and improving the diversity of the workforce. Any comments from you on that?

Dr. Orlowski: We are strong supporters of the same efforts that the AMA, and again, we've worked closely together on this. Probably the most striking figure that we have looked at is Black men in medicine. And essentially the number of Black men in medicine is unchanged from 1970. So, the number of medical students have gone up but the number of Black men in medicine hasn't. And we do know that we need to diversify our medical schools, our residencies. And I think as we have taken a look, we have participated in a summer health education program. AMA has similar programs that they've been involved in. It really is encouraging the pipeline of a diverse group of students to take a look at medical school. And so, it's not just being good in the STEM fields and being able to go to a good college. It's how do we continue to sort support people with scholarships? How do we make medical school and residency? And we've already talked about the debt that is there.

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The question is how do we continue to support disadvantaged students and show them that there is a pathway for them? So, I think that there's much that we need to do with scholarship assistance. We've talked about mentoring. We continue to support DACA, as I know you have supported DACA as that has gone through. And this will make us a stronger physician workforce if we continue to work on diversity.

Dr. Harmon: Well, Dr. Orlowski, we've had a very good conversation about a lot of things. One big problem, of course, is not having enough doctors in the next 10 years. But there are other huge challenges, not just about enough doctors per se, but the shortages. We've had some conversation about the right types of doctors and specialty, diversity and practice location. We're doing things now to make headway in these areas. What do you think we can do not only now, but in the future beyond what we might have discussed?

Dr. Orlowski: You're right. Dr. Harmon. So, I would say a couple of things. One is to continue to promote those areas where we see shortages. Primary care certainly needs to be promoted. One thing that I would point out that really, really has come to light, we talk about the pandemic and everyone thinks COVID. But I want to think pandemic and think opioid. And we are very, very short of psychiatrists and behavioral health physicians. If we take a look at the aging within different specialties, actually the mean age is extremely high in psychiatry, meaning that we're going to have more individuals retire in that area.

So that is a specialty along with primary care, along with general surgery that we need to continue to encourage people to go into. I had a conversation about a year or so ago with the American College of Surgeons. They are concerned about the numbers and are working to make sure that they support well-being, that they support a diverse workforce. Many of the issues that you and I have been talking about, that the AMA and AAMC have been working on. So, I think all of us need to be involved in that.

And then in regards to different areas, I would say that there's a couple of programs. One is that more medical schools are having regional campuses and that is to provide experience in rural areas or different non-urban areas where physicians are needed. We want physicians to be trained in those areas and we know that they will go to those areas if they have training in that area. So, I think regional campuses is one way.

One very interesting program that I can tell you about is that in the state of Wisconsin, there was a regional medical campus that was opened in the Northern part, a more rural part of the state. And so that campus was opened and they specifically looked at attracting individuals with a rural background, as well as a diverse background. And then with the state and the medical school, what they ended up doing is putting in two residency programs in that area, one in primary care and one in psychiatry. And quite frankly, that's exactly what that area needed. What we know is that upwards of about 60% or so of residents will practice within 15 miles of where they finish their residency. That number used to be 70. It's now lower. It's about 60%. But still if you can retain 60% of residents and you'll have the

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residency in a rural area, that's one of the solutions. So I think that there's creative ways.

The second thing that we have been working with is HRSA. HRSA is taking a look at how they can bring physicians into underdeveloped areas using federally qualified health centers. And so, again, we know that residencies have been developed in these areas and we know through some of the Title VII support, we can bring individuals into residency and then to train and to practice in these underserved areas. So those are two examples where we have been working and looking at making sure we're dealing with some of the really significant geographic disparities that we see.

Dr. Harmon: Dr. Orlowski, one of the things I would comment on, and I've had some conversations with an academician or two, about improving the number of graduate medical education slots. I mentioned that they do have some growth, a thousand here, a thousand there so to speak, and they're limiting them to certain areas and certain types of specialties. They, meaning the government is recommending that we expand, as you said, residency slots in more community-based residencies, which would be great for the physician shortage areas, no question. But I think it does beg the question of how much infrastructure might be in place. If we limit growth, if we as a profession, limit the growth of graduate medical education opportunities to small communities or regional centers that may not have an existing infrastructure of academics. Not necessarily research but just academics and teaching scientists as it were, then it's hard to get some of our surgical specialties or medical oncology type specialties or other specialties that are more organ-based as I would call it as a family medicine specialist.

That you really don't have the teaching infrastructure or the clinical skill set or the clinical range that you might be able to qualify to graduate a fully certified and trained specialist without having more infrastructure in place. And it's going to take a long time to put infrastructure in place to do this.

So, in the short term, perhaps we could ask a bit of a waiver to allow our existing residency programs that have some larger institutions as their academic base to grow their graduate medical education opportunities to help provide the specialty care that we are anticipating, you at the AAMC and we at AMA are anticipating being physician short specialty areas in the coming decades.

Dr. Orlowski: Yeah. I couldn't agree with you more. You know what? It's expensive to educate medical students and residents. It really is. And as we take a look at the large academic medical centers who, they have professionals in adult education and the infrastructure that's needed for residency programs. So, I agree with you. If a rural hospital or a rural clinic is interested, I really think partnering so that the infrastructure is there is absolutely what we need to do. The AAMC on our website has a PowerPoint presentation that anyone can take a look at that talks about sort of the cost and the resources that you get. And people always think, "Oh, you get money from the government if you have graduate medical education." And well, believe me, we're grateful that we have some money but it doesn't cover all the expenses. It is expensive to have an educational program.

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On the other hand, though, as I've talked to some areas that I would say is atypical to have residency programs, I think you have to take a look and say, "Why are they doing this?" So, for example, HCA, very large chain of health systems, hospitals across the United States. They have gotten into the graduate medical education business over the last couple of years. Now HCA is not known for academics. That wasn't their core competency. But as they took a look at the number of physicians that they needed and that they needed to continue to have in order to support their hospitals and their ambulatory clinics, they understood that they needed to participate. And so, you saw, actually under Jonathan Perlin, an expansion of their GME program. And I mentioned that Dr. Perlin now is moving over to The Joint Commission. So, we'll watch and continue to see if HCA continues this.

The other group that has gotten into training medical students is Kaiser. Now Kaiser did have residency programs before but not medical schools. And Kaiser took a look and said, “As part of this need for physicians, we need to participate and we're going to open a medical school that is supported by the Kaiser Permanente Group.” So, I think that you see many systems saying, "We know it's expensive. We have to do this right, but we need to be part of the solution." And so, we're seeing a growth of residency programs in not just the large, typical academic medical centers but we're seeing growth throughout.

You and I have talked about the support needed for the historical Black colleges, which really are the place where diversity in workforce, where the most physicians of color are trained. And we need to continue to support HBCUs but we also need to diversify our other medical schools. So, these are all areas that we need to continue to support and work on. And the bottom line is we have a growing number of medical students and we need more residents.

Dr. Harmon: We do. And I think to kind of put to rest, I've heard some of my patients when I describe the physician shortage because I have a shortage here in my community. We talk about not enough family doctors and everybody's worried when I'm going to retire, what are we going to do? How many doctors will it take to replace me and my practice? And I understand all of that. And we do see right now a gap that doesn't have a lot of quick fixes.

The point is you can't just quick fix a doctor supply. It takes years of training for physicians to be qualified. You can't just say, "All right, we need more doctors in five years. Let's turn out more." To your point, it takes years of college and medical school, graduate, post-graduate medical education. You're looking at a seven-to-10-year career, after a year or two of college, before we can enter the workforce.

Dr. Orlowski: That's right. And what we have said to the federal government is, "Wake up, look at what the shortage is. And if we are going to affect the shortage that we anticipate in 10 to 15 years, we must act today." It is absolutely needed. And you know, people talk about, “Oh, physicians are trying to control the number of doctors.” Actually, couldn't be further from the truth. If you take a look, the schools that have opened since the 2000s, some of these are state schools. Some of these are

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private schools. Really, there's no one organization that can control that. Now, certainly the AMA and the AAMC, in partnership, have for a long time supported the LCME, which is the accreditation of medical schools. But there's nothing that says only this number of doctors. We have said, if you have the resources and you meet these accreditation standards, there's no limit to the number that get approved.

And so, I think the growth of medical schools over the last 15, 20 years is an example that there really is no impediment to the growth of medical schools. It's just an impediment to have the resources and the time and the people who dedicate themselves to having a very solid, very good medical school.

Dr. Harmon: Absolutely. And I'll comment, not only at students getting into medical school but to your point, typically, traditionally medical schools have a couple of years of basic science where you learn the pharmacology, the cell physiology. You learn the language of medicine. You learn the science. Then you have a couple of years of clinical experience. And the third- and fourth-year medical students really have to struggle, to my experience and your commentary earlier, in finding clinical practice locations.

Because to the point that we have a physician shortage, that means we have less opportunities, especially in the rural communities where I live, for physicians that are already busy and very burdened with their clinical to take care of the growing patient population in physician shortage areas, to take on the extra task, not a burden but the task in their workday to teach and train and become that role model and mentor for medical students is problematic.

So, we really have a problem now that urges Congress to open up the opportunities for us to get more training slots and to incentivize physicians to reduce those barriers to patient care, barriers to physician satisfaction and wellness, so that they can have the time and the energy and the enthusiasm to train these medical students and have them experience how much fun and joy it is in being a doctor.

Dr. Orlowski: You and I, Dr. Harmon, have talked about the need for the federal government to step up support. One thing that I would remind individuals who are listening to this is that there is a role for state and local governments as well. And so, we both at AAMC and the AMA have supported areas. I'll give you an example. In Texas, as they've taken a look at the tremendous shortage that they've had, they actually have built medical schools in Rio Grande and in Tyler. They've taken a look at their state and from a state economic, how are we going to support the people? What they've said is besides schools and places to work, we need to have a solid health care system within Texas.

And so, you see that state governments have a role in helping to support new medical schools. But also right now, there are about 40, 43 states and the district provide some support to graduate medical education. And that support needs to not only stay but we need to take a look and say, "Are the states and the local governments doing enough to support residencies?" So that's another area for people to

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become involved in and to encourage and to make sure their representatives understand what the shortage is and what can be done to help it.

Dr. Harmon: To your point. I've had some personal conversations. Many of my physician colleagues in organized medicine have the same conversations with state legislators who are asking, "Well, let's just have another medical school, Dr. Harmon in the state." It is good to have a medical school but they need to understand that we have to have the graduate medical education opportunities. And that's a very good resource to bring on board, as the state legislature and the state economic support is critical to taking care of our patients and making sure that health care for all becomes a reality. That is a great idea.

Dr. Orlowski: Absolutely. And when you say care for all, I'm going to take us in a sort of another direction that we have to talk about. The numbers that we look at, that we've been looking at as we start with today's numbers in regards to access and the number of physicians, and we say, "Okay, we know there's a shortage in primary care and in psychiatry," but let's take a look at the growth under a couple of different scenarios. If we had more doctors, if managed care was different and we look at all of these scenarios. The one part of the report that I'd like to make sure I highlight is that there's a part that says equity of utilization. And that's a fancy word that we were trying to say that right now, there is not equity in access to physicians.

We know that the white population has a greater access than the African American, the Hispanic and other people of color. And so, one of the calculations that we do is a calculation that says, what if everyone had the same access? And if everyone had the same access, we would need more than a hundred thousand physicians today. So, you and I have talked about the growth that we need based on the population and the aging of the population and sort of the system staying and growing as it is.

The other calculation that is in our most recent report challenges the current status and says let's not grow a system that just grows off of the current base, so to speak. But let's have a system where there is access and there's equity of utilization to all populations. And those numbers become even larger. So, as we seriously, we as Americans seriously take a look at equity and our role in looking at and promoting diversity and equity and inclusion, the numbers that we need for an adequate physician workplace are even larger.

Dr. Harmon: Impressive numbers and sobering numbers, I would say. The AMA's strategic mission is to advance the art and science of medicine and the betterment of public health, and to your point, the betterment of public health for all. So, health equity is an accelerator for all of our strategic arcs and clearly the AAMC understands that and lives that recommendation as well. We have quite a challenge ahead in our physician workforce.

Dr. Orlowski: We do.

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Dr. Harmon: Dr. Janis Orlowski, you've just been so gracious for joining us. I want to thank you so very much for that and the AAMC's extensive work to draw people's attention that this very serious matter of a physician workforce shortage. I hope the two organizations can continue to work together to make sure our nation has the physician workforce it needs take out and take on the tremendous health care challenges we face today and far into the future. I really appreciate you joining us today, Janis.

Dr. Orlowski: Thanks so much, Dr. Harmon. Thank you to you. Thank you to the AMA. It's with our organizations working together, and quite frankly, working with our members that we're going to fix this problem. So, thank you so much for inviting me today. It's a tough conversation but if we all understand what the issues are, we're going to find a solution. Thank you.

Dr. Harmon: Dr. Janis Orlowski, thank you again so very much.

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