WRITING BOARD

We Need More Doctors

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As Covid-19 strains our healthcare system, it also highlights the growing problem of a physician shortage in the U.S. This article seeks to understand why we are failing to produce enough doctors to meet a growing demand, and to explore how we can combat this issue by increasing funding for residency programs and easing restrictions on foreign-trained physicians.

As the coronavirus disease 2019 (COVID-19) pandemic worsened and hospitals began to fill up in New York City in March 2020, New York Governor Andrew Cuomo called on retired physicians and nurses, asking them to consider going on call as the crisis worsened in his state.¹ With the impacts of COVID-19 disproportionately affecting older individuals, this was not an ideal solution. This call for help was necessitated by the fact that there is a shortage of medical personnel needed to combat this crisis. However, the physician shortage existed before the COVID-19 pandemic. While our current situation has highlighted this problem, the deficit of physicians has been a growing crisis of its own for many years.

In 2019, the Association of American Medical Colleges published data confirming a growing physician shortage. The data projected a shortage of up to 122,000 physicians by 2032.² These projections account for the growing number of physician assistants and advanced practice registered nurses, with the massive physician shortage remaining despite the growth of these fields. Furthermore, the Association of American Medical Colleges report suggests that if health care use patterns were equalized across race, insurance coverage, and geographic location, we would need an additional 95,900 physicians immediately.²

To combat this growing problem, we must start by understanding why it exists in the first place. From 2002 through 2019, medical school enrollment increased by approximately 30%; however, residency programs have struggled to grow due to funding constraints.³ Graduate medical education (GME), or residency programs, are largely funded by the federal government through Medicare.⁴ Despite the growing need for more physicians, Medicare funding for GME has not increased in more than 20 years as a result of the Balanced Budget Act of 1997.³ This law sought to cut government spending in order to reduce the federal government's annual deficit. This was accomplished, in part, by permanently limiting the number of medical residents that could be counted for GME payments to the number of trainees that existed in 1996,

unless a new law is passed to lift this limit.³ Since this law is still in effect, the federal government has not been able to fund additional residency spots at existing GME programs in 24 years.

One of the outcomes of this legislation is that as medical school enrollment increases, the number of residency spots cannot match that increase. This produces a bottleneck in the process of producing greater numbers of physicians. Thus, the US cannot truly combat the physician shortage without legislation that breaks this bottleneck by increasing GME funding. Furthermore, if medical school enrollment continues to rise without a proportional increase in GME positions, we will see more medical school graduates fail to match into residency. While increasing GME funding is an important part of combating the physician shortage, there are other potential steps that can be taken to help alleviate this crisis.

There are many non-US-trained physicians living in the US that could help drastically curb this problem if they were allowed to practice medicine. The process to gain a license to practice in the US after completing medical school elsewhere is arduous and leaves out many previously trained non-US physicians. Physicians trained outside the US must not only take the tedious and expensive United States Medical Licensing Examination board exams, but also complete a full-length residency program, even if they have completed a residency abroad.⁵ This is true for physicians who complete residencies in other highly industrialized nations with advanced health care systems, such as France, Japan, and the UK, with the only exception being Canada.⁶ This forces non-US-trained physicians to compete with US trainees for residency spots. Thus, the current system forces trainees from the US vs those from outside the US into the same bottleneck identified above, which is not the most efficient way to combat the physician shortage.

Nevertheless, physicians trained outside the US can be an important part of solving the physician shortage. In fact, approximately one-quarter of active physicians in the US are currently overseas-trained physicians who overcame the many obstacles to gain licenses to practice.⁷ Without these physicians, the physician shortage would likely have been much larger.

Still, there are better ways to integrate these physicians into practice in the US. For instance, looking to Canada's process of granting medical licenses to physicians trained in other countries much easier. Many Canadian provinces allow immigrant physicians to practice family medicine without completing a Canadian residency.⁶ Additionally, there are residency waivers for some specialties that allow physicians trained at select programs across the globe to practice without completing an additional Canadian residency program.⁶ The US should follow a similar model: allow primary care physicians trained abroad to practice without completing a US residency and evaluate specialty training programs from abroad to grant waivers to physicians trained in programs that meet certain acceptable standards so that they do not have to complete a US

residency. Additionally, if there are significant concerns that these changes might grant licenses to physicians that do not meet US standards, there could be a modified training program for these physicians.

One example for how this program could be set up would be to have physicians trained abroad complete a year of practice under the supervision of an attending before being given a full US license. Essentially, the program would be a 1-year residency program, except it would consist of spots that are separate from the current GME placements. Additionally, this program could be designed to place non-US-trained physicians in underserved regions where help is always needed. Thus, the program could free up additional residency spots for US-trained physicians by providing a separate program for physicians trained outside the US, and it could be used to help provide health care to those who need it most. While this example may not provide a robust enough solution, it highlights a model for how we could better position non-US-trained physicians to combat our growing physician shortage and deliver optimal health care to the American people.

COVID-19 has highlighted how important a well-functioning health care system is to our society. However, regardless of whether we are facing a pandemic, everyone will need a physician at some point in their lives. On our current trajectory, many people who need a physician will simply not be able to see one because the demand is far outpacing the supply. Our need for trained medical professionals is growing, and our supply of physicians is failing to keep up. To combat the physician shortage, we must break the bottleneck and increase funding for residency programs. We must also go further and use the under-tapped resource of physicians trained abroad by allowing avenues that bypass the existing GME system. In doing so, we can help ensure a future where everyone who needs a physician has access to one, including when we are facing the next major public health crisis.

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