# Physician Employment in 2000 and Beyond

*Joseph Hawkins*

For the past two decades, physician recruiters have lived by the maxim, "There is no such thing as an unemployed physician." Is this maxim still true today, and will it hold true for the next two decades? "Yes!" is the answer. Most of today's physicians and the physicians practicing within the next two decades will be able to pursue their respective specialties, although perhaps not in the location that they most desire.

Most academic and other physician supply experts agree that the United States currently has too many physicians and that the days of full physician employment are numbered. A 1994 article in *JAMA* forecast that the United States will have a surplus of 160,000 physicians by the year 2000, including a surplus of 135,000 specialists and 25,000 primary care physicians.[1] A survey published in *JAMA* in 1998 indicated that, of the residents who completed their training in 1996, 11% of the physicians seeking jobs as general internists were still unemployed 6 months after completing their residencies, as were 6.7% of radiology residents, 7.3% of anesthesiology residents, and 9.4% of pediatric residents.[2]

Several organizations, including the Pew Health Professions Commission[3] (San Francisco, CA) and the National Academy of Sciences Institute of Medicine[4] (Washington, DC), have advocated a reduction in the number of residency programs, residency positions, or both. Under a pilot program, the Health Care Financing Administration (Baltimore, MD) is paying hospitals in New York state *not* to train residents.

Despite others' concern about a physician surplus, Merritt, Hawkins & Associates (a physician recruiting firm) and this author envision good opportunities for physicians in the year 2000 and beyond. The reason for this optimism lies in the physician employment markets—past, present, and future.

## HISTORIC VIEW OF THE PHYSICIAN EMPLOYMENT MARKET

### Early 1900s

At the turn of the 20th century, America was rife with physicians who were pouring out of 130 medical schools—more medical schools than exist today. Although the ratio of physicians per 100,000 population in 1900 approached current levels, the number of physicians at that time was less of a critical issue than was the quality of their training (**Table 1**). Without strict state licensing policies and high educational standards, the process of becoming a physician (or at least assuming the title) was relatively easy. With the Flexner Report[5] and the advent of rigorous licensing procedures, the landscape of medical education and licensing changed. By 1925, the ratio of physicians per 100,000 population decreased dramatically and the number of medical schools decreased to approximately 80. The physician supply was limited for the next 40 years because of educational and licensing requirements; however, this constraint did not precipitate a health care crisis.

### The 1960s: Fear of a Physician Shortage

In the 1960s, fears about a physician shortage loomed as the Baby Boomer generation began to enter adulthood. According to the Bureau of Health Professions (Washington, DC) increased funding became available for new medical schools and between 1965 and 1988, 40 new medical schools were established, and medical school enrollment doubled. Congress relaxed immigration restrictions, which led to an influx of international medical graduates (IMGs). From 1980 to 1993, the number of practicing physicians in the United States grew by 40%, whereas the general population only grew by 8%.[6]

### The 1980s: Popularity of the Specialist

By 1980, the pendulum had swung back from the 1960s: health care experts were now concerned about a physician surplus, not a shortage. In 1980, the Graduate Medical Education National Advisory Committee (GMENAC) (Washington, DC) predicted a surplus of 70,000 physicians by 1990 and a surplus of 137,000 physicians by the year 2000.[7]

During this period of physician growth, a bias against primary care was built into medical education

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and medical economics. In this author's experience with recruiting physicians, many physicians confided that this bias was reinforced by teachers who told them as medical students not to "waste their talents" by going into primary care. The relatively higher incomes of specialty medical practice combined with more "regular" hours also persuaded many students to eschew primary care. As a result, specialists came to dominate the ranks of medical students.

Applications to medical schools also began to decrease in the 1980s. At this time, medicine—with its expensive and grueling training—seemed less attractive to many young people than the legal profession or Wall Street, where money could be made more quickly. Meanwhile, the geographic distribution of physicians remained uneven, with a disproportionate number of physicians practicing in large urban areas, close to where they trained.

### The 1990s: Popularity of the Primary Care Physician

Just as primary care's popularity reached its nadir, health care reform and managed care gained momentum. By the early 1990s, a country-wide shift to a primary care gatekeeper system appeared imminent. During most of the 1990s, primary care physicians enjoyed the kind of employment climate that most professionals can only dream of. Primary care physician incomes increased dramatically, and the number of practice opportunities exploded. In the early 1990s, medicine was again viewed as an attractive profession, offering job security at a time when downsizing and general employment uncertainty prevailed in other fields. Medical school applications increased throughout much of the 1990s, although applications decreased in 1999.

Furthermore, medical students heard the message about primary care—they now recognized the key role of primary care physicians in context of the evolving health care marketplace. According to the Association of American Medical Colleges (AAMC) (Washington, DC), for the past 5 years more than 50% of medical school graduates have selected primary care residencies (personal communication, 1999). The American Medical Association (AMA) (Chicago, IL) reports that, between 1995 and 1997, the number of general internists increased by almost 10%, from 115,168 to 128,435.[8] The number of family practitioners grew by 9%, from 59,109 to 64,310, whereas the total number of physicians expanded by only 5% during that time.[8] This trend shows that growth in primary care outpaced growth of specialties, indicating that medical students are moving towards where they think the jobs are.

Despite this growth, the geographic maldistribution of physicians remains. In fact, more health professional shortage areas exist today than 10 years ago. IMGs, who were commonly thought to be more inclined to practice in under-served, rural areas than United States graduates, have not ameliorated the maldistribution problem. A 1998 study published in *Medical Care Research and Review* suggests that IMGs actually contribute to the problem of geographic maldistribution.[9] "In virtually all cases," Politzer et al[9] write, "IMG distributions are less even than those of their U.S. counterparts." That is, instead of being more inclined to practice in under-served areas, IMGs actually may congregate in urban areas more than United States medical graduates.

Not surprisingly, the number of searches that Merritt, Hawkins & Associates conducted for primary care physicians increased from 55% of all searches in 1991 to 73% of all searches in 1996. During this feeding frenzy for primary care, the firm conducted primary care searches in traditionally physician-heavy areas, such as Santa Barbara, CA, and Sarasota, FL. The health care press addressed the issue of specialists retraining to become generalists,[10] and a few specialists actually took this step.

**1997: Another shift in trends.** But a funny thing happened to specialists on the way to the unemployment line. Starting in 1997, the managed care bandwagon began to slow down. Encouraged by a strong economy, health care consumers began rejecting the

*(continued on page 79)*

**Table 1.** Patient-Care Physicians* Per 100,000 Population

| Year | Total Patient-Care Physicians | Patient-Care Physicians per 100,000 Population |
|---|---|---|
| 1965 | 259,418 | 132 |
| 1970 | 278,535 | 134 |
| 1975 | 311,937 | 142 |
| 1980 | 376,512 | 163 |
| 1985 | 448,420 | 185 |
| 1990 | 503,870 | 200 |
| 1995 | 582,131 | 222 |
| 1997 | 620,631 | 232 |

*The term *patient-care physicians* refers to physicians who actively provide patient care and excludes licensed physicians who are no longer providing full-time patient care (eg, physicians in a research setting).

Adapted with permission from *Physician Characteristics and Distribution in the U.S.* Chicago, IL: American Medical Association, 1999.

*(from page 75)*

gatekeeper model in managed care. Point-of-service plans offering greater access to specialists gained popularity and market share. Legislation prohibiting health maintenance organizations from denying patients physician access gained momentum in many states. Suddenly, specialists were popular again.

This shift is reflected in the types of searches requested by the clients of Merritt, Hawkins & Associates. In 1997 and 1998, primary care searches conducted by this firm decreased by 17%, whereas searches for specialists increased by 40% to approximately 47% of all searches. In 1999, approximately 50% of the searches conducted by Merritt, Hawkins & Associates were for specialists. Oncologists, cardiologists, and orthopedic surgeons are in particular demand; even hospital-based specialists (eg, radiologists and anesthesiologists) are in demand. An emerging type of hospital-based physician, the hospitalist, is also in increasing demand.

### Year 2000

As the year 2000 begins, the massive glut of physicians predicted by GMENAC[7] and the more recent *JAMA*[1] study does not appear to be evident. Although some physicians apparently have difficulty finding jobs, the number of unemployed physicians is minimal. It is true that median income for physicians dropped 1.2% in 1997, the most recent year tracked by the AMA. However, median income rose 4.4% and 4.6%, respectively, the two previous years.[11] Although demand for many specialists is not reflected in 1997 income growth, that trend may change when income figures for 1998 and 1999 are eventually analyzed. The income for primary care physicians has increased sharply over the past 5 years and may be reaching a plateau.

Meanwhile, what type of employment market do physicians face today?

## CURRENT PHYSICIAN EMPLOYMENT MARKET

### General Considerations

With some exceptions, today's national physician employment market is quite favorable. Although the market for primary care physicians has cooled recently, this slight downturn in the market is only relative to its previous heat. In 1997 and 1998, Merritt, Hawkins & Associates conducted 585 searches for family practitioners, more than any other specialty, followed by 231 searches for internists, 124 searches for obstetrician/gynecologists, and 97 searches for pediatricians. It appears that these specialties also will be the most requested searches in 1998 and 1999 from Merritt, Hawkins & Associates (data is still being compiled and assessed).

Primary care physicians can still find practice opportunities in most sections of the country. However, their "superstar" status has diminished for several reasons, one of the reasons being the slowing of the managed care juggernaut alluded to earlier in this article. Another reason is a Newtonian reaction: Hospitals, health networks, and medical groups focused so exclusively on establishing primary care networks in the past several years that many ignored their specialty services. These organizations are now addressing these previously neglected needs.

In addition, anecdotal evidence suggests that a higher percent of older physicians are choosing early retirement to opt out of managed medicine, creating service gaps. A number of hospitals that work with Merritt, Hawkins & Associates in smaller to mid-sized communities are fighting patient migration to metropolitan areas by augmenting their specialty services through recruitment.

### The Relationship of the Primary Care and Midlevel Provider Markets

The market for primary care has also cooled for yet another reason. Midlevel providers, such as physician assistants (PAs) and nurse practitioners (NPs), are increasing in number and influence. According to the American Academy of Physician Assistants (Arlington, VA), currently in practice are 34,000 PAs (18% more than in 1996) and 63,000 NPs (more than twice the number in 1990) (personal communication, 1999). Furthermore, the Balanced Budget Act of 1997 expanded settings in which PAs and NPs can work and increased their Medicare reimbursement levels, enhancing their attractiveness to employers. Some of the clients of Merritt, Hawkins & Associates, who in the past probably would have added a family practitioner to their practice, have added a PA or an NP instead.

Long-term, however, this author does not believe that midlevel providers are a threat to physician employment. The reason is twofold—technological trends and the nature of American society. This era is one of specialization, in which every field (regardless if it is law, sports, broadcasting, dining, or travel) is evolving away from the general and toward the technical. This trend is particularly true in medicine. Whether this evolution occurs through performing more angioplasties, improving cataract surgery, access to better diagnostic equipment, performing more joint replacements, development and use of new drugs, or development and use of genetic testing, medicine is becoming more technical and more specialized.

Meanwhile, the American consumer, who is benefiting

**Table 2.** United States Cities with Lower-Than-Average Physician-to-Population Ratios*

**Alabama**
Birmingham
Dothan
Huntsville
Mobile
Montgomery
Tuscaloosa

**Arizona**
Mesa
Phoenix
Tucson

**Arkansas**
Fort Smith
Jonesboro
Little Rock
Springdale
Texarkana

**California**
Bakersfield
Chico
Fresno
Modesto
San Bernardino
Stockton

**Colorado**
Colorado Springs
Fort Collins
Greeley

**Florida**
Bradenton
Fort Myers
Gainesville
Hudson
Jacksonville
Lakeland
Ocala
Orlando
Ormond Beach
Panama City
Pensacola
Tallahassee
Tampa

**Georgia**
Albany
Atlanta
Augusta
Columbus
Macon
Rome

**Idaho**
Boise
Idaho Falls

**Illinois**
Aurora
Elgin
Joliet
Peoria
Rockford
Springfield
Urbana
Bloomington

**Indiana**
Evansville
Fort Wayne
Gary
Indianapolis
Lafayette
Muncie
Munster
South Bend
Terre Haute

**Iowa**
Cedar Rapids
Davenport
Des Moines
Dubuque
Iowa City
Mason City
Sioux City
Waterloo

**Kansas**
Topeka
Wichita

**Kentucky**
Covington
Lexington
Louisville
Owensboro
Paducah

**Louisiana**
Alexandria
Baton Rouge
Houma
Lafayette
Lake Charles
Monroe
Shreveport
Slidell

**Michigan**
Dearborn
Detroit
Grand Rapids
Kalamazoo
Marquette
Muskegon
Petoskey
Saginaw
St. Joseph

**Minnesota**
St. Cloud

**Mississippi**
Hattiesburg
Jackson
Meridian
Oxford
Tupelo

**Missouri**
Cape Girardeau
Columbia
Joplin
Springfield
St. Louis

**Montana**
Great Falls

**Nebraska**
Lincoln
Omaha

**Nevada**
Las Vegas
Reno

**New York**
Binghamton
Syracuse

**North Carolina**
Charlotte
Durham
Greensboro
Greenville
Hickory
Raleigh
Wilmington
Winston-Salem

**Ohio**
Canton
Columbus
Dayton
Elyria
Toledo

**Oklahoma**
Lawton
Oklahoma City
Tulsa

**Oregon**
Bend
Salem

**Pennsylvania**
Allentown
Altoona
Danville
Erie
Harrisburg
Lancaster
Reading
Sayre
York

**South Carolina**
Charleston
Columbia
Florence
Greenville
Spartanburg

**South Dakota**
Sioux Falls

**Tennessee**
Chattanooga
Jackson
Kingsport
Knoxville
Memphis
Nashville

**Texas**
Abilene
Amarillo
Beaumont
Bryan
Corpus Christi
Dallas
El Paso
Fort Worth
Harlingen
Houston
Longview
Lubbock
McAllen
Odessa
San Angelo
Temple
Tyler
Victoria
Waco
Wichita Falls

**Utah**
Ogden
Provo
Salt Lake City

**Virginia**
Lynchburg
Newport News
Richmond
Roanoke
Winchester

**Washington**
Tacoma
Yakima

**West Virginia**
Charleston
Huntington
Morgantown

**Wisconsin**
Appleton
Green Bay
La Crosse
Neenah

*Includes both primary care and specialist physicians.

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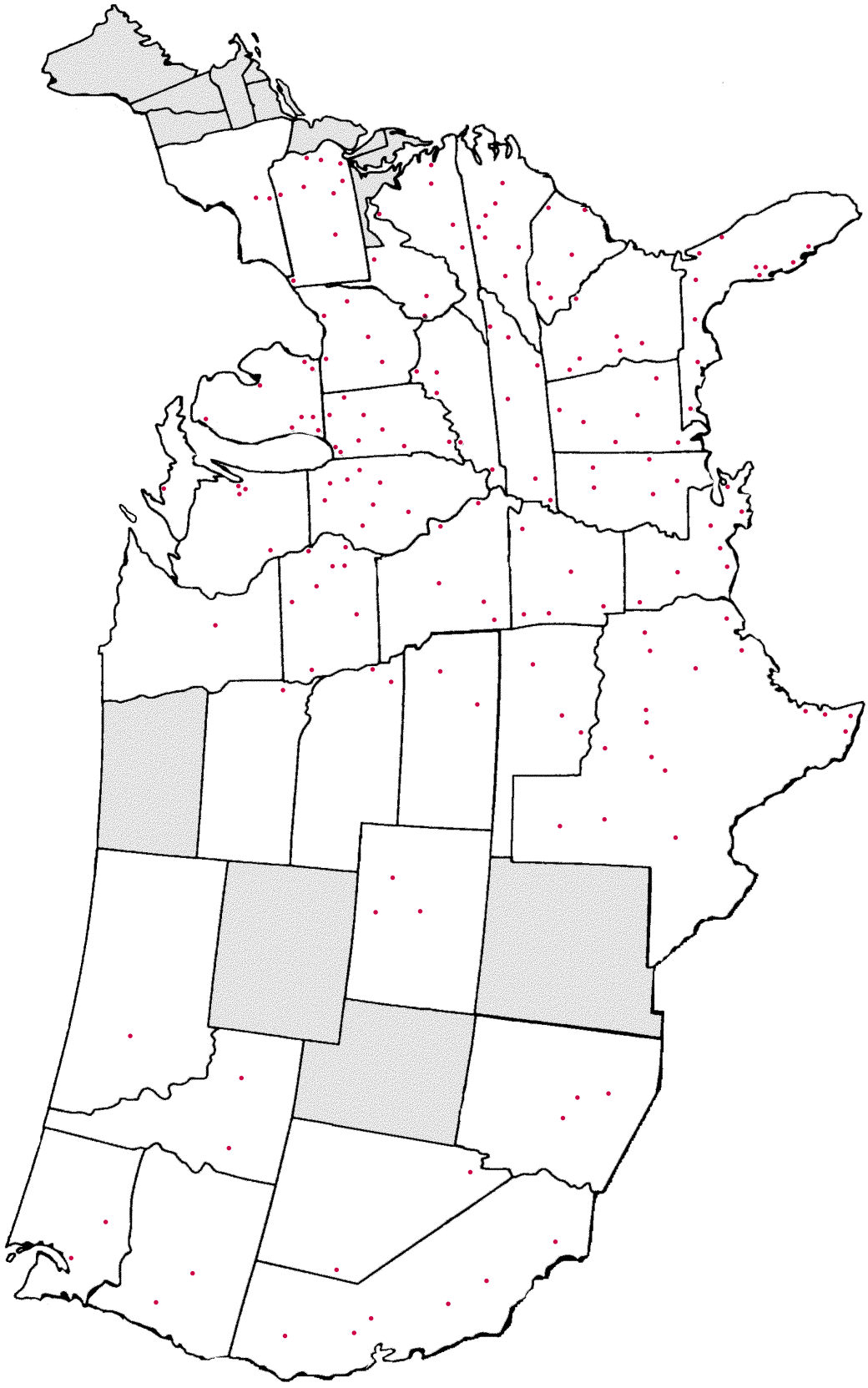

**Figure 1.** Approximate locations of United States cities with lower-than-average physician-to population ratios, including both primary care and specialist physicians. Data for Hawaii and Alaska are not included. Grey-shaded states do not have cities with lower-than-average ratios.

from a booming economy, is becoming more demanding. Many patients have the income to afford health plans that offer "choice." The concept that patients are content consulting a family physician when they want to consult a dermatologist or a gastroenterologist or that patients will consult a PA when they want to consult a pediatrician or an internist seems untenable.

### Geographic Considerations: Physician Opportunities in the United States

Although physicians may not be able to find secure practices in some regions, particularly major metropolitan centers of the Northeast and West Coast, many communities exist in which physicians can find practices with immediate financial security and long-term growth potential. **Table 2** and **Figure 1** show markets that have lower-than-average physician-to-population ratios for both primary care and specialist physicians.[12] Physicians who are seeking employment opportunities may wish to consider these communities.

### Other Market Considerations: Training

A physician's skill and level of training are important factors when considering the current physician employment market. Medical training in the United States generally is preferred by most employers who hire physicians. Data indicate that IMGs have more difficulty finding jobs than American medical graduates. The *Survey of Final Year Medical Residents*,[13] conducted by Merritt, Hawkins & Associates in 1999, shows that IMGs in primary care receive significantly fewer job solicitations during their residencies than United States medical graduates. According to the 1998 *JAMA* study,[2] 47% of IMGs with green cards had difficulty finding a job, whereas only 28% of United States medical graduates had difficulty.

In addition to having trained in the United States, most hospitals and medical groups are looking for physicians who are likely to be active for an extended period, and therefore prefer physicians in their forties or younger. Female physicians, particularly obstetricians and gynecologists, are in great demand. These observations are based on what this author and colleagues have seen in the market.

Perhaps even more important, employers are seeking physicians who are adept at practicing in today's medical environment, which emphasizes teamwork, patient satisfaction, and conservative utilization of resources. Physicians with good patient rapport and the ability to provide quality care with an eye to appropriate utilization are at a premium.

These many factors are the reasons that most hospital administrators with whom this author speaks do not subscribe to the notion of a "physician glut." From the perspective of a potential employer of a physician, few candidates who fit their specific parameters are available. If a physician glut truly existed, the thousands of physician recruiters and hundreds of recruitment firms would not be in business in the United States today.

## FUTURE PROSPECTS: WHERE THE PHYSICIAN EMPLOYMENT MARKET IS HEADED

### General Considerations

Twenty years ago, health care experts predicted a major physician surplus by the year 2000, which did not occur. Is a surplus on the horizon? This author does not believe so.

The market is an effective regulator of physician supply. In the past 5 years, students gravitated toward primary care, helping to fill a market-driven need. Now that specialists are back in demand, there is evidence that the demand for primary care physicians is slowing down. Although more than 50% of United States graduating fourth-year medical students will begin training in primary care this year, the overall number of family practice matches among United States medical school graduates was 7.8% lower than in 1998, according to the AAMC.[14] Internal medicine matches also decreased, whereas pediatric matches increased slightly. Should any real physician glut materialize, the market will adjust for it. Fewer students and their families will make tremendous sacrifices to enter a field in which employment opportunities are difficult or impossible to attain.

The growing number of women in medicine will also affect physician employment, particularly in primary care. The AAMC reports that currently 60% of obstetrics/gynecology residents are female, as are 56% of pediatric residents, 41% of family practice residents, and 32% of internal medicine residents (personal communication, 1999). Clearly, the primary care providers of tomorrow will be heavily represented by women. According to the AMA, female physicians work 7 fewer hours per week than their male counterparts, which will significantly reduce total physician work hours as their numbers grow.[15] Concurrently, younger physicians in general are moving away from the traditional, independent model of medical practice toward an employed model, in which practice hours are more structured and standard benefits include "time off."

### Patient Demographics

Patient demographics will also play a role in the trends of the physician employment market. According

to the Health Care Financing Administration, adults older than age 50 years spent hundreds of billions of dollars on health care in 1999 and will spend approximately twice as much by 2007. The United States Census Bureau reports that the number of people age 65 years or older will grow from 35 million today to 75 million in the year 2030. This trend provides a great opportunity for physicians, although a different opportunity than was expected 15 or 20 years ago. The elderly will not be as chronically ill. Through medical and lifestyle improvements, the elderly will be relatively healthy and active. As the first wave of the Baby Boomer generation reaches their 80s in 2030 and beyond, today's medical residents will be established physicians treating the active elderly; the demand for rheumatologists, endocrinologists, orthopedists, oncologists and urologists is likely to be strong.

### Technology

Technology will continue to be an influential factor on physician employment trends. For every new breakthrough in surgery, diagnostics, and treatment modalities, new specialists will be needed. The proliferation of noninvasive techniques is likely to increase patient demand as surgery becomes less problematic. Innovations such as telemedicine will help achieve a more even geographic distribution of physicians; for example, more physicians may realize they can have ready access to their "electronic peers" while living in more relaxed, family-friendly, rural settings.

Although increasing the demand for physicians, technology may also affect the physician supply. Merritt, Hawkins, & Associates has already seen older radiologists accelerate their retirement, in part because they are unwilling to learn new modalities. Physicians with training in the latest technology will be at a premium.

### Quality Initiatives, Health Care Funding, and New Markets

Quality initiatives may also have an effect on the physician supply. If reliable outcomes data are achieved on a national scale, physicians who do not measure up may be "weeded out" of the system, in much the same way that poorly trained physicians were eventually reduced by higher educational standards following the Flexner Report. Highly rated physicians, by contrast, will have an abundance of employment opportunities.

Health care funding is another influential factor—one that is particularly difficult to gauge. Currently, the political will appears to exist to not only maintain Medicare, but to expand member benefits. Given reasonable economic growth in the next 20 years, sufficient funds may likely be available for high-priority services, such as health care, regardless of how such services are paid for. Given a sustained economic downturn, funding may erode and physicians, like any other workers, may find it more difficult to maintain employment and income.

The potential of new markets also must be considered. An increasing number of affluent or needy patients from other countries are seeking out United States medical care, making the American health care system a "growth market." In addition, the development of new pathologies (eg, AIDS) or the effect of environmental or man-made disasters on the need for physicians is also difficult to predict. In the long term, society may be better off having too many physicians rather than too few.

### SUMMARY

Physicians should not plan their careers around the latest physician employment prognostications. As the renewed demand for specialists shows, the medical market is mercurial. One cannot time trend changes any more than one can consistently time the stock market—and trying to do so is a mistake. A well-trained physician, with good leadership skills and a true passion for his or her specialty, will find a welcome employment opportunity. Physicians must choose their career path accordingly.

### NOTE

Additional physician employment information can be found on Merritt, Hawkins & Associates' Web site at *www.mhagroup.com*. **HP**

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