Physician Shortage Malpractice Impact and Risk Solutions

Explore 2025

Graham Billingham, MD, FACEP, FAAEM

MedPro Group
a Berkshire Hathaway company

Speaker bio

Graham Billingham, MD, FACEP, FAAEM, Chief Medical Officer, MedPro Group (Graham.Billingham@medpro.com)

Dr. Billingham has 40 years of experience as an emergency medicine physician. He speaks nationally and internationally and has lectured in more than 400 continuing medical education courses on risk management, operations, patient safety, documentation, information technology, coding and billing, and malpractice prevention.

As MedPro's Chief Medical Officer, he is responsible for leading the company's Risk Solutions department and working with other leaders to support clinical risk, claims, underwriting, and sales efforts. His team focuses on improving patient safety and outcomes, decreasing risk and preventing claims before they happen.

Prior to joining MedPro, Dr. Billingham served as president and CEO for EPIC RRG. He also served on the physician advisory boards of several technology companies and the American College of Emergency Physicians' Medical Legal Committee and Coding and Nomenclature Committee. He is emeritus chairman of the Emergency Medicine Patient Safety Foundation and has served on the Emergency Department Practice Management Association's Board of Directors.

Dr. Billingham also founded and served as medical director for the Center for Emergency Medical Education and was a co-founder of the National Emergency Medicine Board Review Course.

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When there are relevant financial relationships mitigation steps are taken. Additionally, the individual(s) will be listed by name, along with the name of the commercial interest with which the person has a relationship and the nature of the relationship.

Today's faculty, as well as CE planners, content developers, reviewers, editors, and Risk Solutions staff at MedPro Group, have reported that they have no relevant financial relationships with any commercial interests.

Agenda

Overview of healthcare staffing challenges

Factors contributing to staffing challenges

Litigation in healthcare staffing

Strategies to mitigate staffing challenges

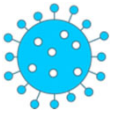
Future outlook and recommendations

Healthcare Staffing Challenges

Healthcare delivery changes

Corporatization of medicine

Including private equity investments



CV19 impact on population health

Deferred care, missed care, etc.

Healthcare consolidation

Larger, more complex healthcare systems

Healthcare staffing

Contract staffing, provider burnout, turnover, violence

Physician employment

Less private practice, more corporate/hospital

Scope of practice

Expanding for PAs, NPs, CRNAs, etc.

Shifting environment of care

More outpatient, home health, telehealth, etc.

Technology innovations

Artificial intelligence (AI), genetics, etc.

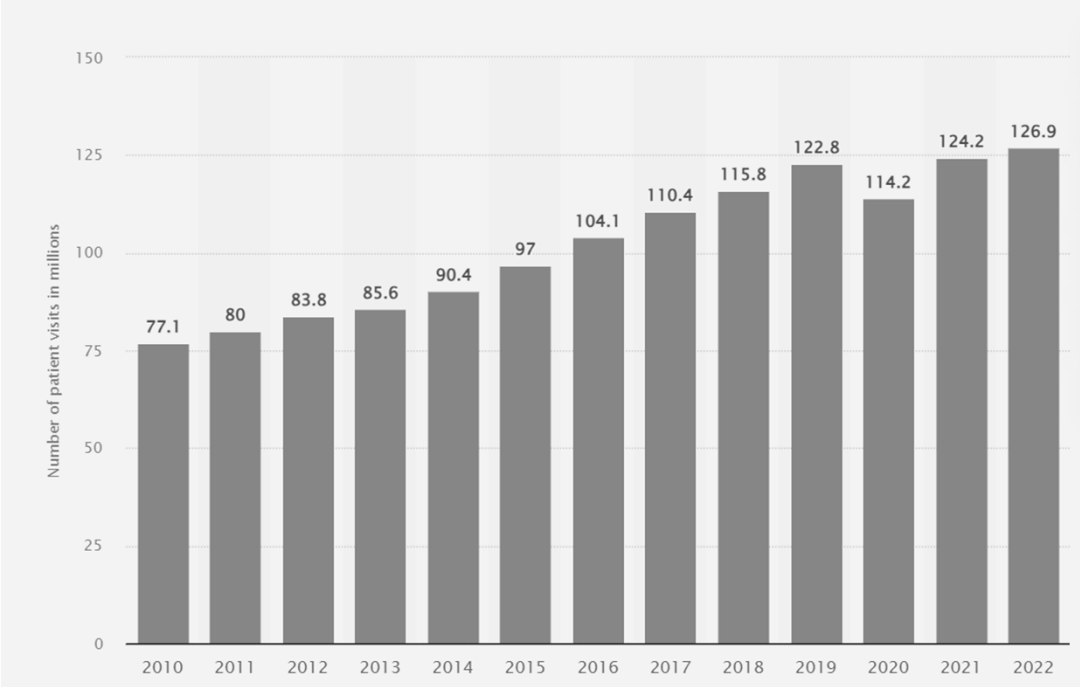
The problem: Physician supply vs demand

Projected supply of and demand for physicians, 2026, 2031, and 2036

	2026	2031	2036
Supply	919,370	938,510	969,740
Demand	1,027,220	1,073,150	1,109,680
Surplus / (Shortage)	(107,850)	(134,640)	(139,940)
Percent Adequacy	90%	87%	87%

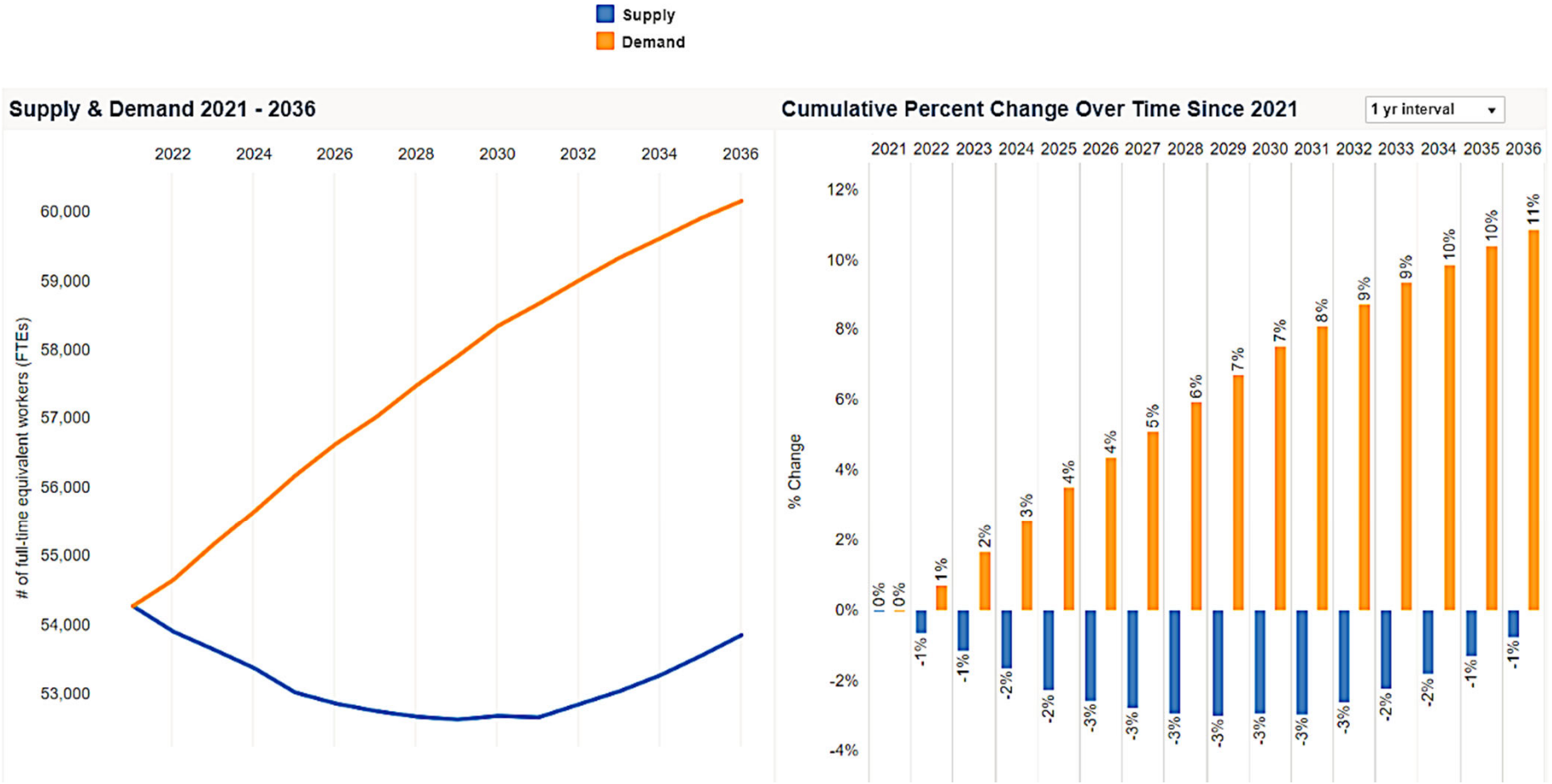
Source: Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections. Available at https://bhw.hrsa.gov/data-research/review-health-workforce-research

Total number of US health center patient visits



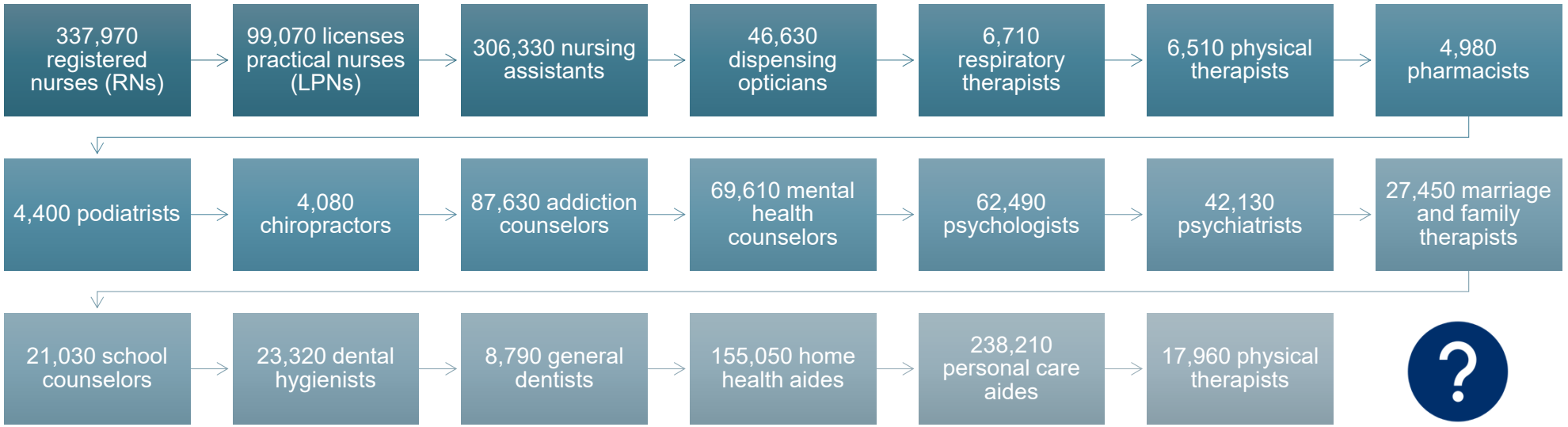
Retrieved from: https://www.statista.com/statistics/755207/health-center-patient-visits-in-us/

All healthcare workforce



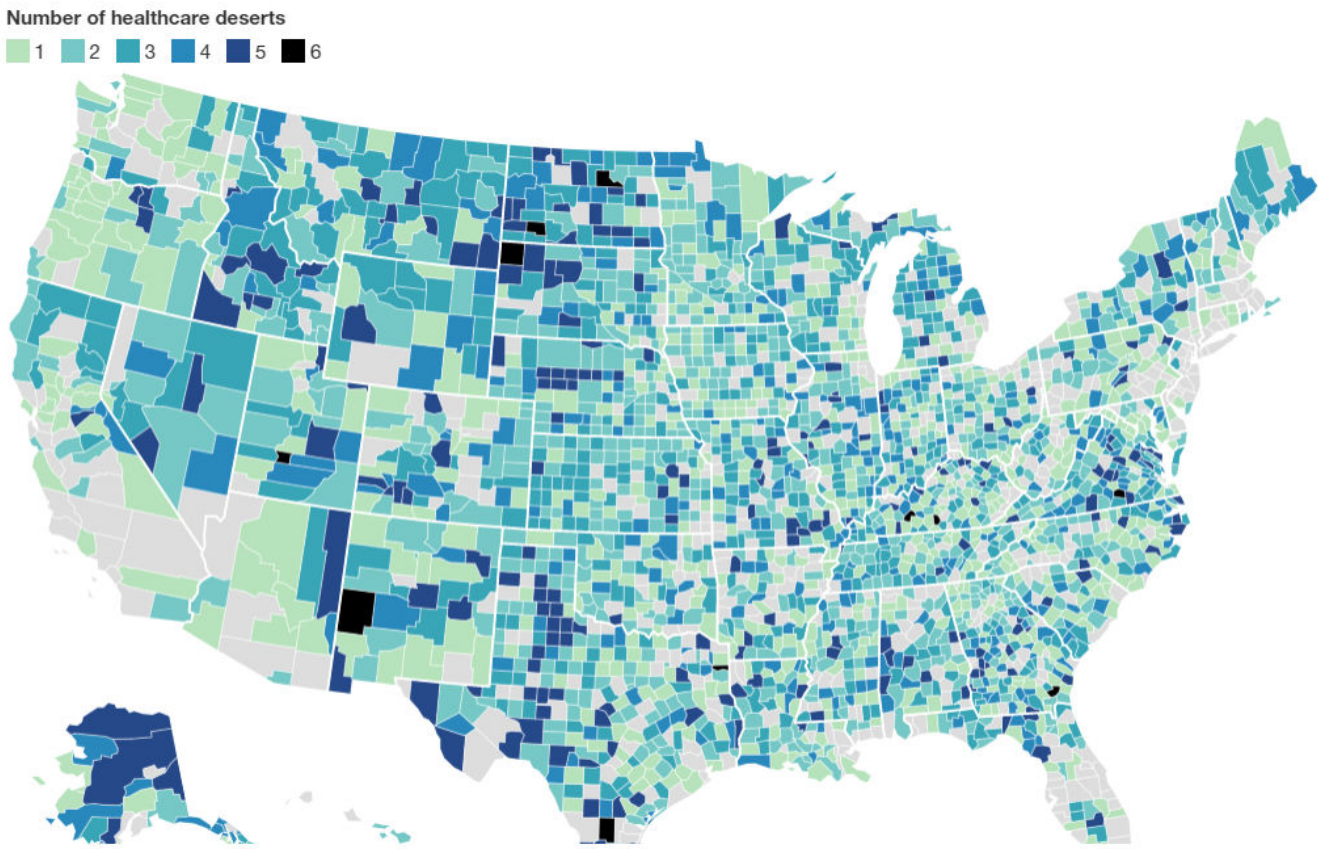
It's not just the docs

Over the next 15 years (through 2036), NCHWA projects shortages in many key allied health occupations, including:



Retrieved from: https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand

We are creating healthcare deserts



Healthcare Deserts, County by County

Consumer sentiment: digital technology

45% of consumers own a wearable health device or use a smartphone to track wellness

More than 1 million smart rings were sold in 2022

More than 7 million continuous glucose sensors were sold in 2023

Bloomberg estimates the wearables market will grow to $76 billion by 2028

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57% believe the data is useful and want their doctors to collect it

74% of millennials prefer teleconsultations to in-person appointments

Contributing factors

Workforce issues

- Insufficient staffing
- Burnout: High-stress workload can cause healthcare workers to leave the profession
- Training bottlenecks: Limited capacity in medical and nursing schools can restrict the number of new graduates entering the workforce

Economic factors

- Insufficient funding for healthcare systems can limit resources available for hiring and retaining staff workforce

Demographic disparities

- An aging patient population often requires more healthcare services, straining existing resources
- Chronic conditions can increase the demand on healthcare services

Policy and regulation

- Complex licensing processes can delay the entry of qualified professionals into the workforce

Contributing factors

Geographic disparities

- Rural areas experience more shortages of healthcare providers
- Healthcare deserts

Technological changes

- Introducing new technologies may outpace the training and adaptation of healthcare personnel

Insurance and access issues

- Insurance limitations: Changes in insurance coverage can affect the number or patients seeking care and the types of services available

Social determinants of health

- Inequities: Socioeconomic factors can affect access to care and the ability to respond to community needs

MPL Impact

Biggest Known Risk: step-change in severity

Headwinds driving a step-change in severity for US HCL insurers

Eroding Legal Environment

Legislative and judicial actions are weakening tort reforms and creating more plaintiff-friendly laws in many states.

- Increased non-economic damage caps
- Expanded wrongful death actions
- Loosened “venue-shopping” rules
- Increased exposure due to joint & several liability
- Higher pre-judgment interest rates

Unpredictable Courtrooms

Shifting jury demographics and attitudes are amplifying the complexity of defending healthcare providers and taking cases to trial.

- Desensitization to monetary values
- Distrust of institutions, experts & science
- Receptivity to plaintiff attorney tactics like reptile theory & anchoring

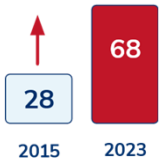
Healthcare Delivery Shifts

Healthcare systems and providers are stressed and operating in unstable competitive, economic, and political landscapes.

- Unrelenting financial pressure
- Staffing shortages, turnover & burnout
- Scope of practice changes
- Alternative sites-of-care
- Emergence of new technologies

Social Inflation

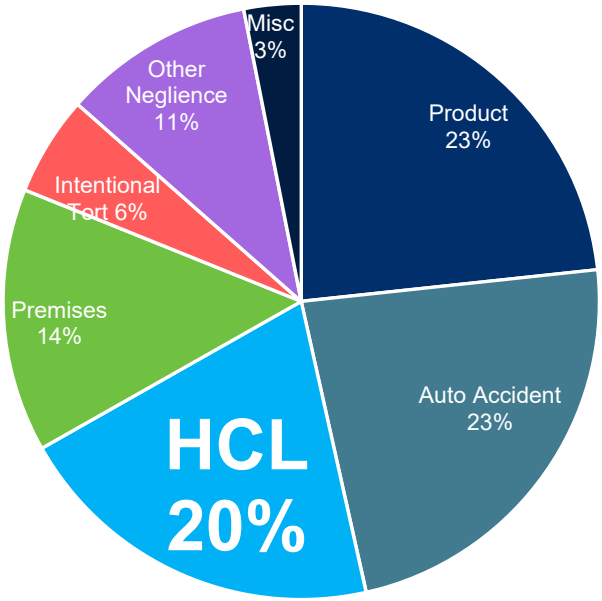
Social inflation is fueling nuclear verdicts and outsized settlements.



- $10M+ verdicts more than doubled from 2015 to 2023
- Those average awards grew from $23M to $40M

Social inflation

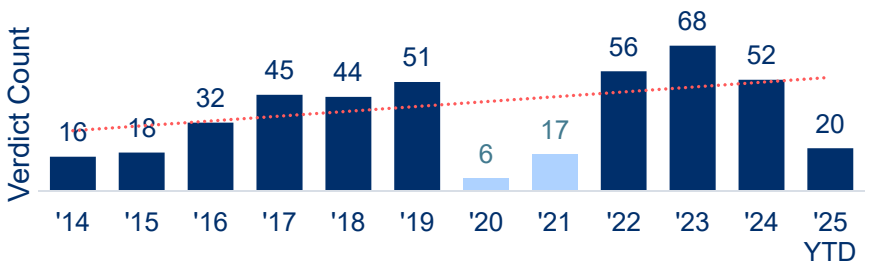
Many factors drive social inflation across many US industries ... HCL is ~20% of nuclear verdicts (economic inflation less a factor now back to historic norms)



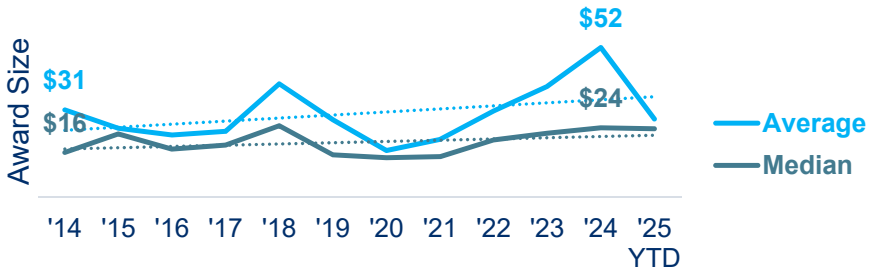
The micro result: US HCL nuclear verdicts continue to increase

Nuclear verdict frequency and severity have risen over the past decade ...
increasing settlement values, and less discounting from verdicts-to-settlements.
Is lower '24 frequency driven by fear of going to trial (also leading to higher settlement values)?

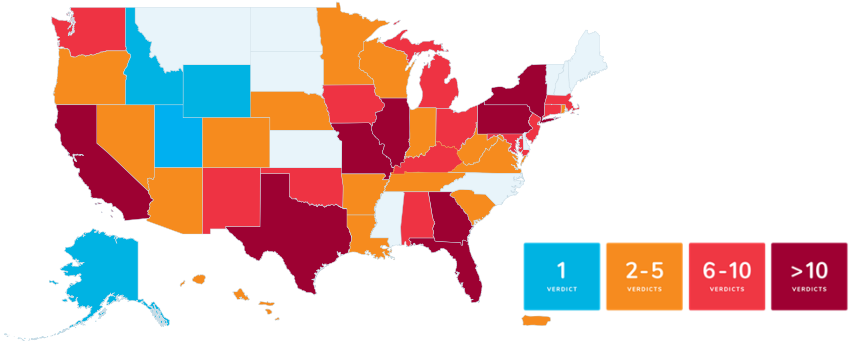
3x more nuclear verdicts (5x > $25)



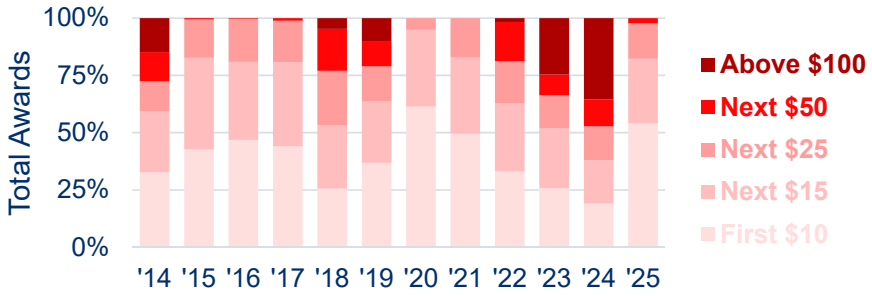
1.5x bigger awards



No longer contained within traditional "judicial hellholes"



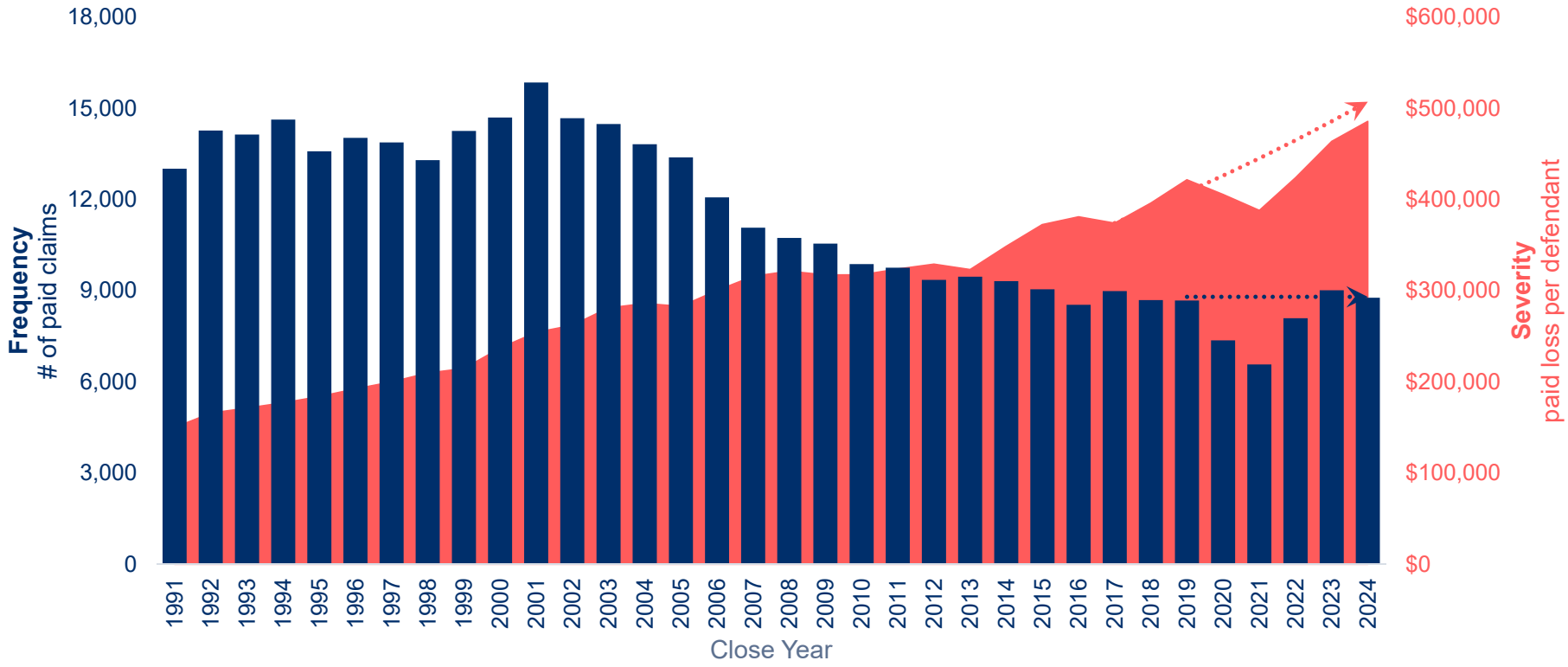
Highest XS layers impacted most



Source: TransRe and various internet articles with publication dates between 01/01/2016 and 04/30/2025.

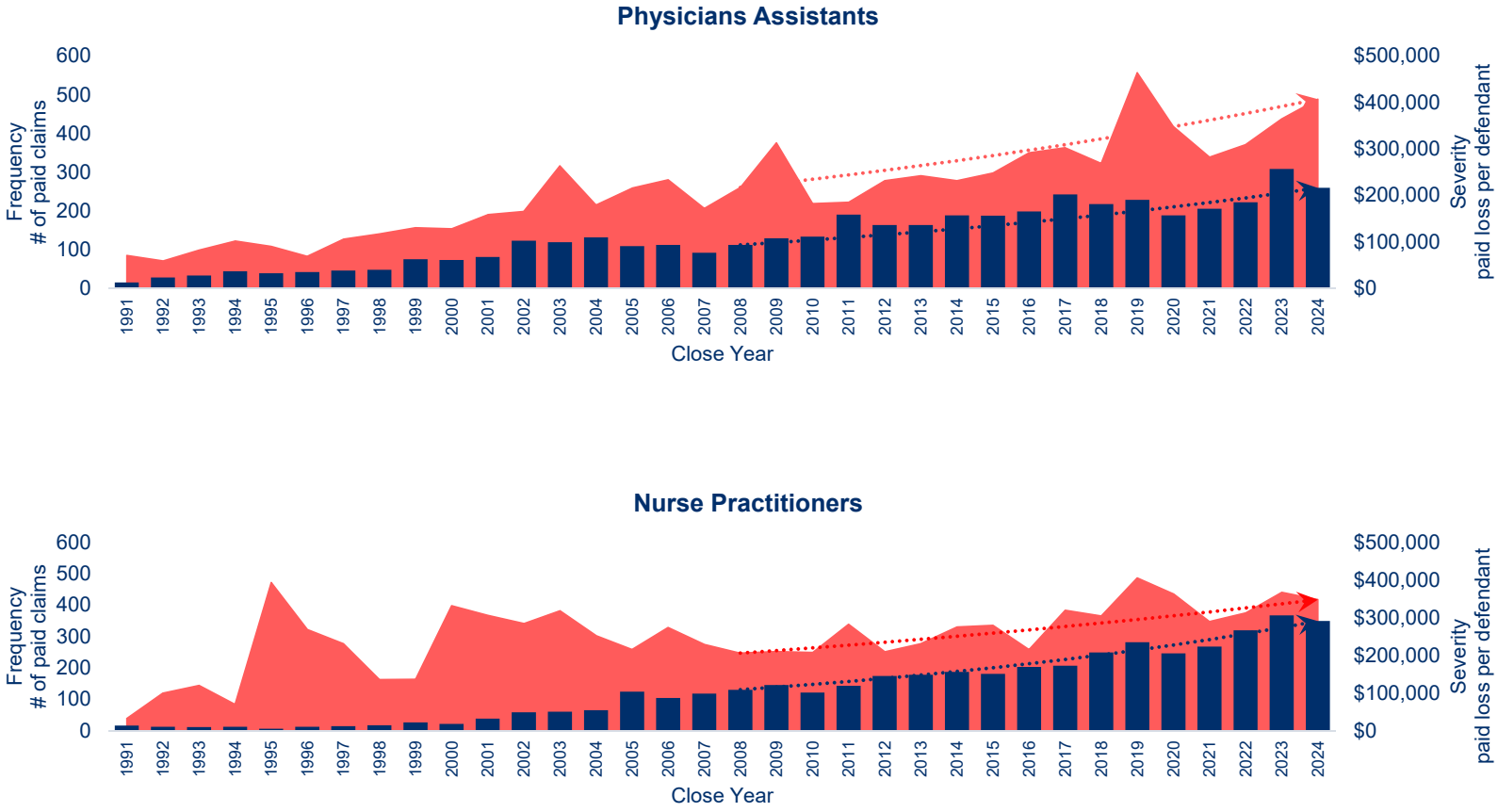
The macro result: increasing loss trends due to severity ...

Industry trends: frequency flat & severity up (excl. impact of CV19).
Will general economic inflation impact these trends?



Source: National Practitioner Data Bank Public Use Data File, December 2024, Physicians, Surgeons, Nurse Anesthetists, Nurse Practitioners, Physicians Assistants, and Nurse-Midwives Countrywide

Severity & social inflation: loss trends for Advanced Practitioners



Source: National Practitioner Data Bank Public Use Data File, December 2024, Nurse Anesthetists, Nurse Practitioners, Physicians Assistants, and Nurse-Midwives Countrywide

Malpractice litigation staffing impact

- Transactional nature of medicine
- Bridge Physicians
- Increased scope of practice
- Work-arounds are dangerous
- Locum tenems and staffing agencies
- Regulatory Compliance with Staffing ratios
- Boarding patients
- Transfers
- Private Equity
- Technology has limitations
- Loss of historical and institutional knowledge
- Does an AI solutions require informed consent?

Challenges

Rural recruiting – school debt relief

Private equity models – mixed blessing – patient vs. profit?

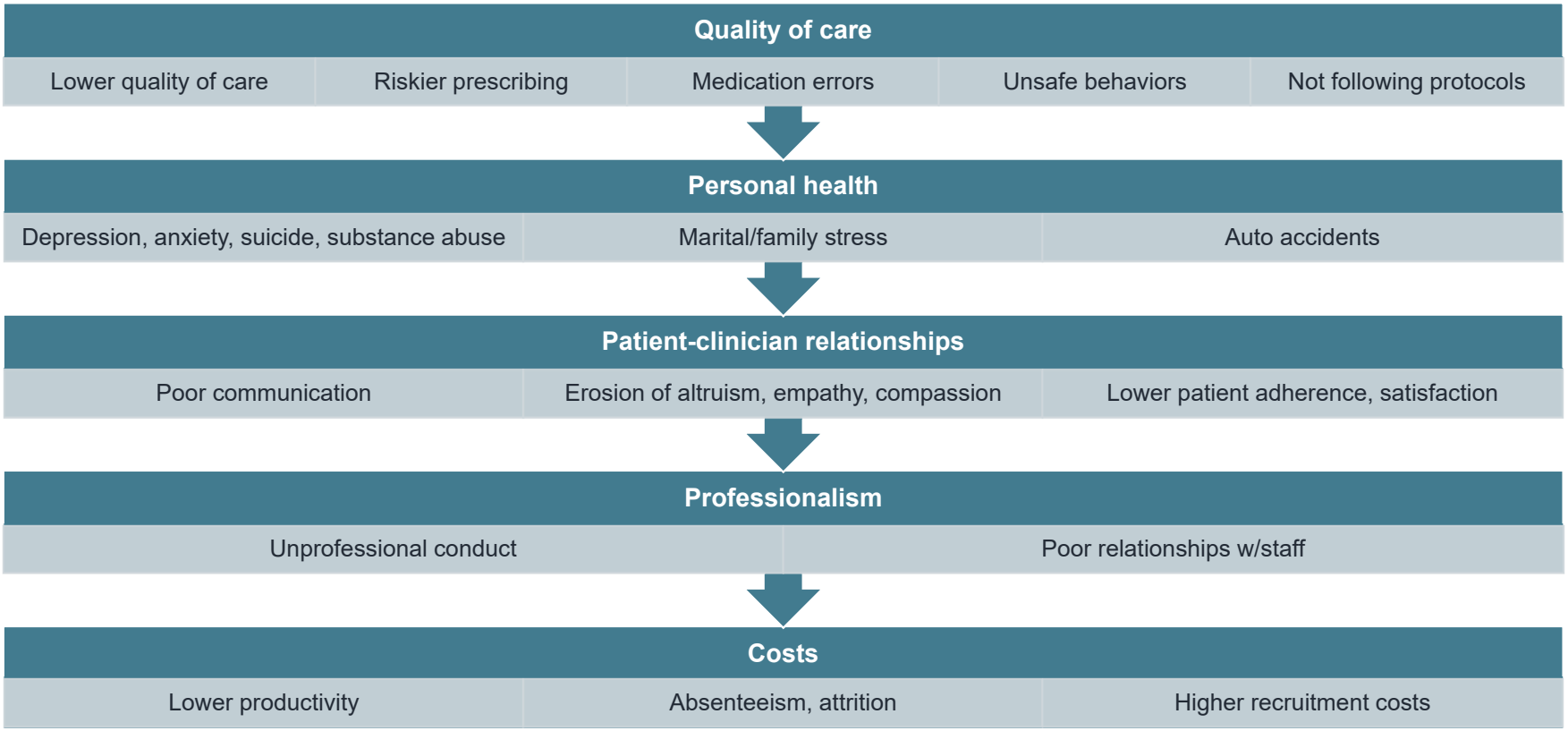
Sub specialization – reimbursement model

How decisions are traditionally made – BOGSATLGW

Physician unions on the rise

Locums tenums

Burnout


Quality of care
Lower quality of care
Riskier prescribing
Medication errors
Unsafe behaviors
Not following protocols
Personal health
Depression, anxiety, suicide, substance abuse
Marital/family stress
Auto accidents
Patient-clinician relationships
Poor communication
Erosion of altruism, empathy, compassion
Lower patient adherence, satisfaction
Professionalism
Unprofessional conduct
Poor relationships w/staff
Costs
Lower productivity
Absenteeism, attrition
Higher recruitment costs

Litigation causes

Malpractice issues

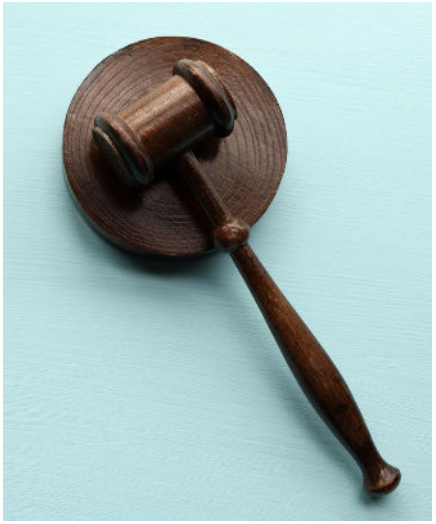
- Malpractice claims arise when healthcare providers fail to meet the standard of care, leading to patient harm. Understanding these claims is crucial in mitigating risk.

Staffing shortages

- Staffing shortages can increase stress and errors among healthcare providers, resulting in potential litigation. Addressing these shortages is vital for care quality.

Regulatory compliance failures

- Failure to comply with healthcare regulations can result in penalties and litigation. Organizations must prioritize understanding and adhering to these regulations.



Agency staff – litigation pressure

Hospitalists

- Increase utilization of hospitalists to assist with the physician shortages
- May be challenges with building relationships with ancillary support departments
- More attention on making sure they are integrated into the organization

Medical/Nursing Students

- An increase in the number of students requires an increase in the number of staff who need to train/supervise
- The importance of scope of practice, supervision, credentialing, and privileging

Increase Utilization of AI Programs

- Potential for an increase in user errors and possibly an increase in patient concerns about the effectiveness of AI, because there is a steep learning curve

Oklahoma Legislation

- **Oklahoma:** Neither the Oklahoma Workers' Compensation Act nor case law directly addresses the exclusive remedy rule in connection with employee leasing situations. The Oklahoma Court of Appeals, however, has held that a worker assigned by a temporary agency to a client company is considered a loan servant, and that both employers are responsible for the provision of workers' compensation, and therefore cannot be sued in a third-party action. *Zant v. People Electric Cooperative,* 900 P.2d 1008 (Okla. App. 1995).

- Van Zant v. Peoples Elec. Co-op. :: 1995 :: Oklahoma Court of Civil Appeals Decisions :: Oklahoma Case Law :: Oklahoma Law :: U.S. Law :: Justia

Oklahoma Scope of Practice

- **HB2298 (Hilbert/Paxton)** – Grants independent prescriptive authority to Advanced Practicing Nurses who meet certain requirements. Passed House; Amended and Passed Senate HHS (SPEAKER/PRO TEM BILL)
- **HB2584 (Hilbert/Paxton)** – Establishes standards related to physician assistants, establishing a pathway to independent practice for PAs meeting certain requirements and setting oversight authority. Passed House; Amended and Passed Senate HHS (SPEAKER/PRO TEM BILL)

- **SB741 (Gollihare)** – Allows pharmacist to test, screen, and initiate drug therapy for nonchronic health conditions. Passed Senate HHS Committee – Title Stricken**; Laid Over on the Senate Floor (OPPOSE) (DORMANT*)
- **HB1173 (Stark)** – Establishes standards for licensed psychologists to prescribe certain psychotropic medication under limited circumstances and with the supervision of a physician. Passed House Public Health; not heard in Oversight Committee (OPPOSE) (DORMANT*)

*DORMANT means the bill did not advance in 2025 but can be reconsidered in 2026

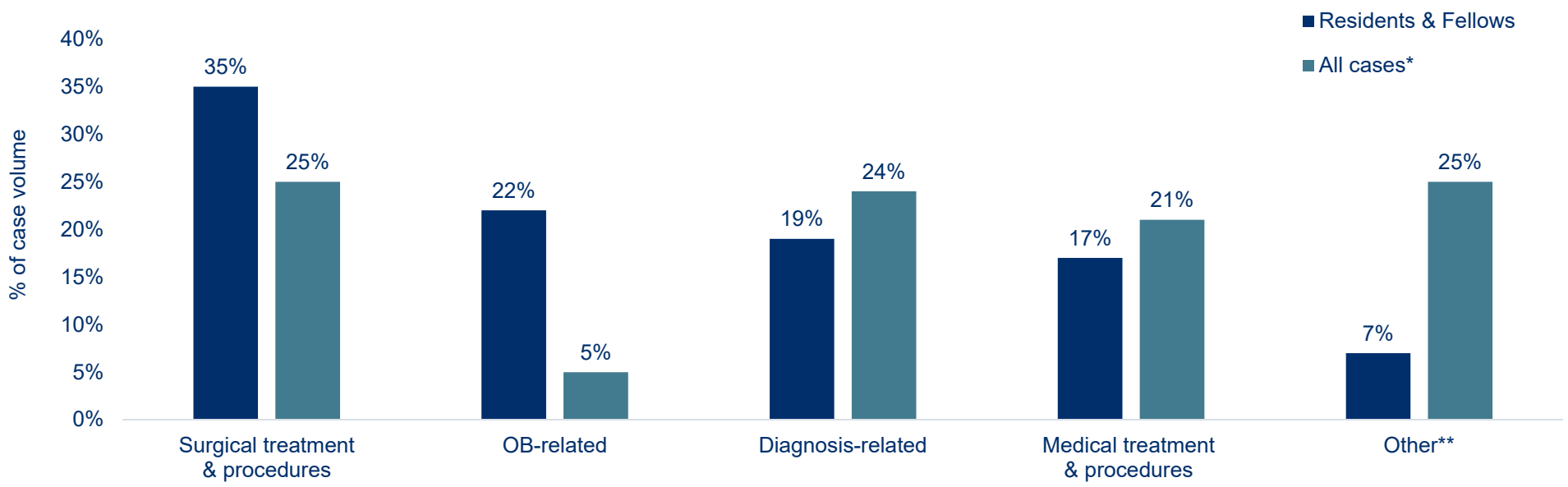
Indemnification clause

To reimburse (another) for a loss suffered because of a third party's or one's own act or default

Subcontractor shall be solely responsible for compliance with the obligations of this clause with respect to any Protected Health Information it retains and shall indemnify, defend, and hold harmless Client and its employees, directors, officers, representatives, and agents from and against any and all claims, obligations, actions, suits, debts, judgments, losses, fines, penalties, damages, costs, expenses (including reasonable attorney's fees), and other liabilities they may incur from Subcontractor's violation of such obligations.

Most Common Major Allegations

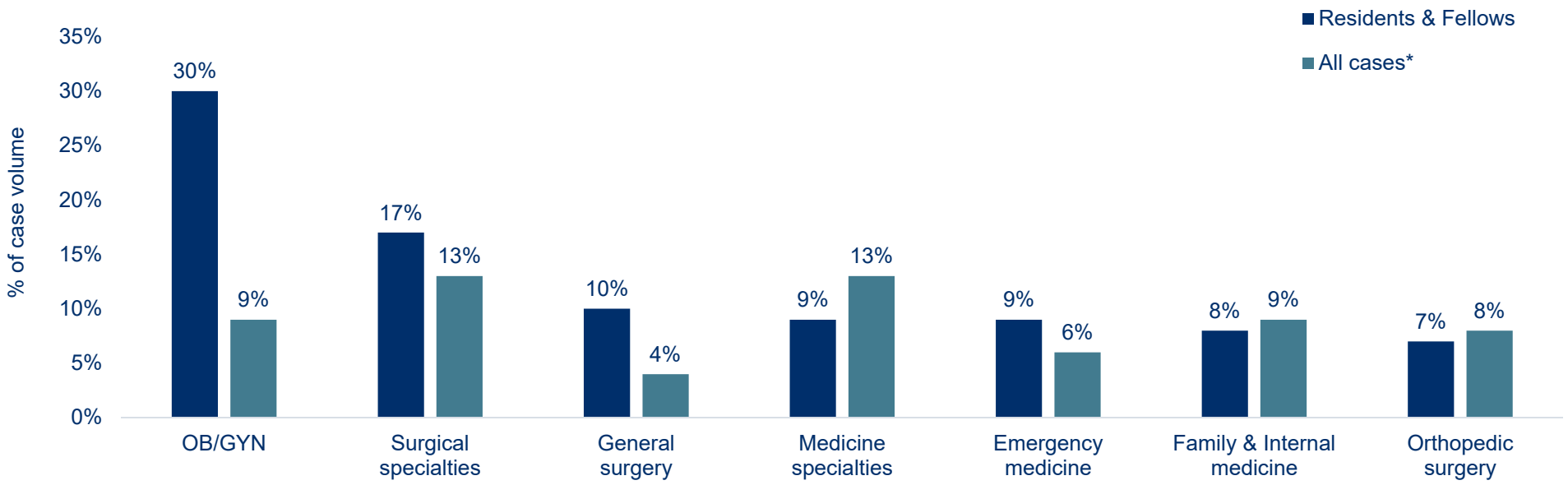
Each case reflects one major allegation category. Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts. The coding taxonomy includes detailed allegation sub-categories; insight into these is noted later in this report. With the exception of OB cases, the distribution of allegations stemming from cases involving residents and fellows is relatively similar to all other cases.



dPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *All cases with any role identified (N=>13K); **Other includes allegations for which no significant case volume exists

Most Common Primary Responsible Services

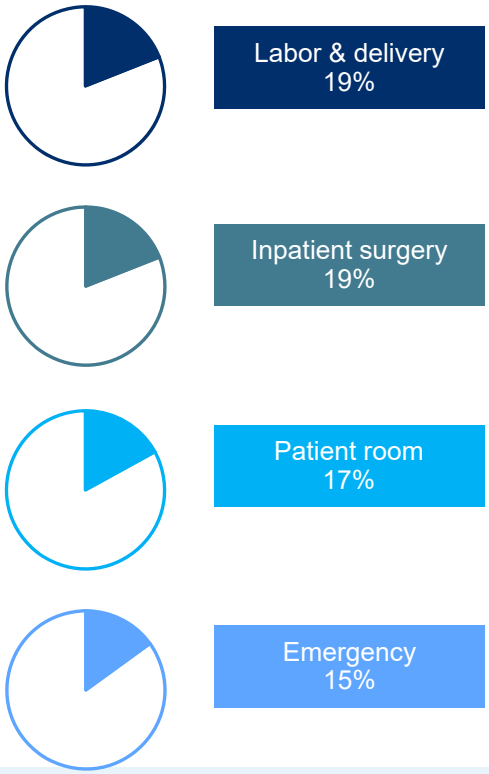
A malpractice case can have more than one responsible service, but the “primary responsible service” is the specialty that is deemed to be most responsible for the resulting patient outcome.
With the exception of OB/GYN cases, and to a lesser extent general surgery, the distribution of primary responsible services stemming from cases involving residents and fellows is relatively similar to all other cases.



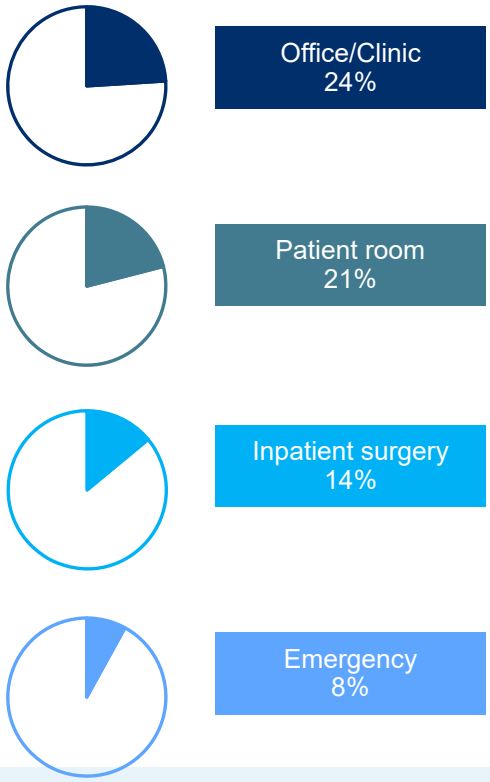
MedPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *All cases with any role identified (N=>13K)

Most Common Locations

Residents & Fellows



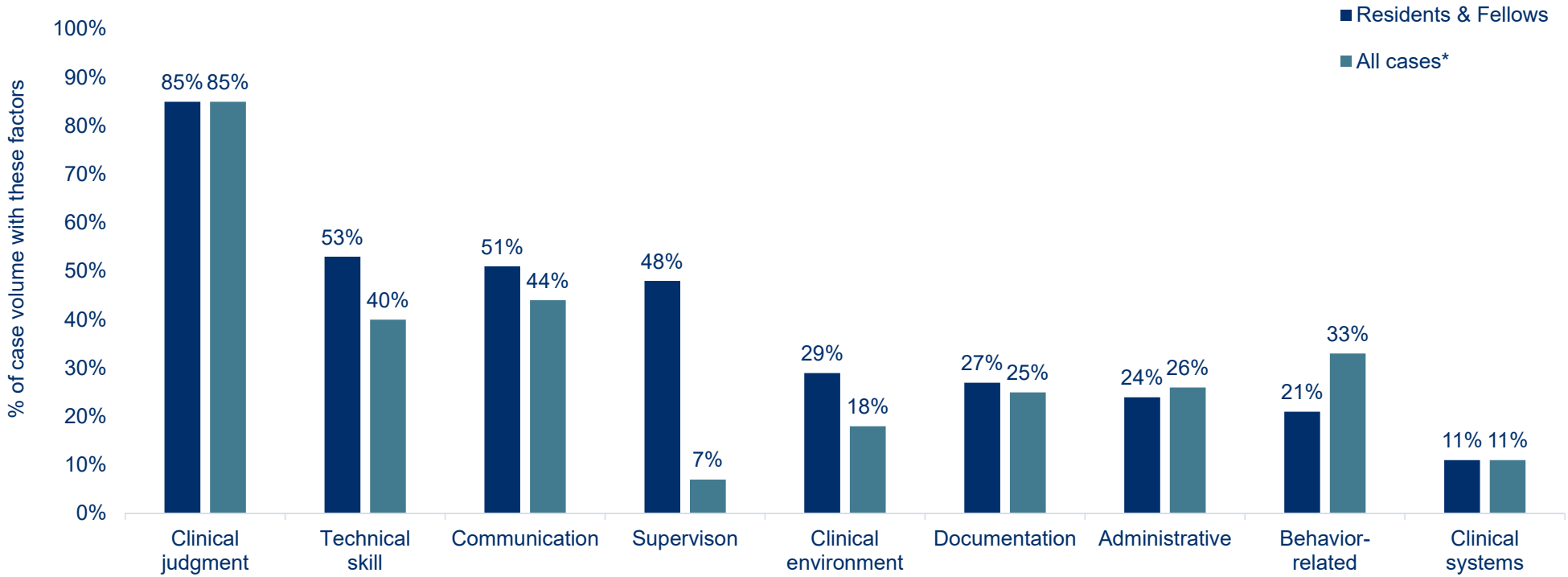
All cases*



dPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *All cases with any role identified (N=>13K); *Severity codes reflect National Association nsurance Commissioners (NAIC) injury severity scale

Most Common Contributing Factor Categories

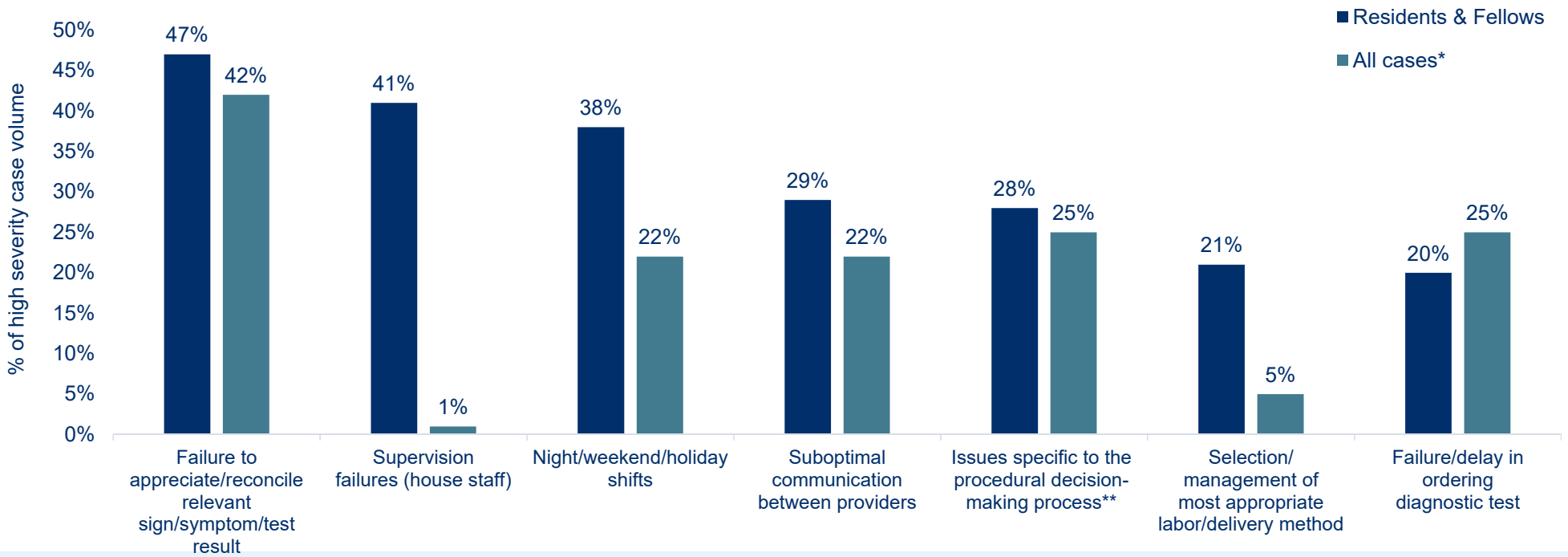
With the notable – and expected - exception of supervision-related factors, and to a lesser extent clinical environment factors, the distribution of contributing factors stemming from cases involving residents and fellows is relatively similar to all other cases.



dPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *All cases with any role identified (N=>13K); More than one factor per case, therefore totals >100%

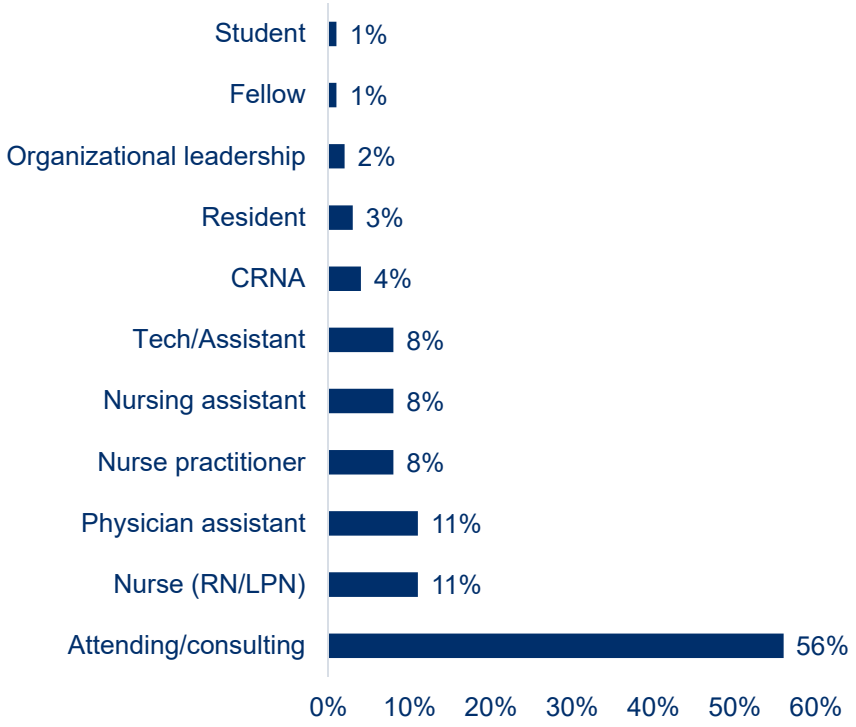
Focus on Most Common Drivers of Clinical Severity

The seven most common drivers of clinically severe patient outcomes for cases involving residents & fellows are noted below, with a comparison to all other cases. As expected, supervision issues continue to be a distinction. Other notable issues include the volume of cases reflecting events arising during nights/weekends/holidays, those involving suboptimal communication (i.e. failure to close the loop), and labor/delivery decision-making.



CRICO/RMF Pro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *All cases with any role identified (N=>13K); More than one factor per case, therefore totals >100%; **Before, during, and after surgeries/procedures, including appropriateness of the patient for the procedure

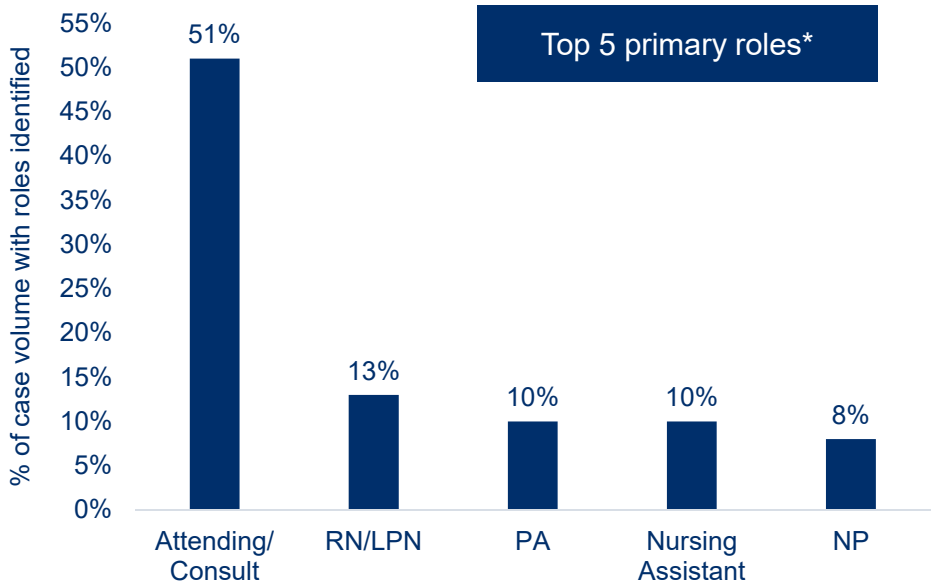
APPs with a primary role in claim

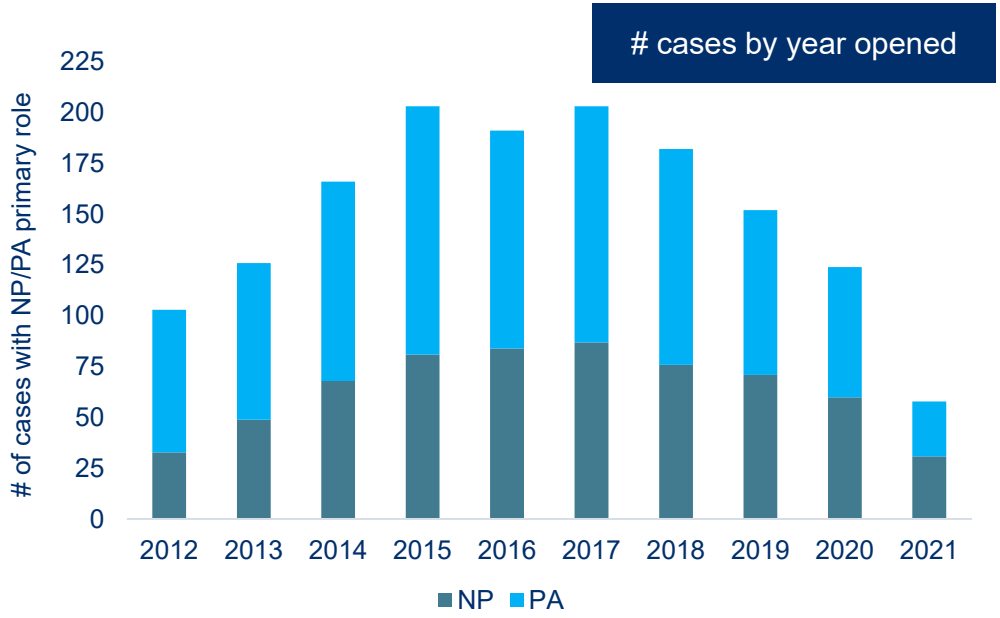


- Credentialing
- Privileging
- Supervision
- Increasing scope of practice
- More patient volume
- More complex patients
- No longer get a free pass
- Compliance with staffing ratios

MedPro Group + MLMIC cases opened 2012-2021 (N=22,625)

Overall Case Volume



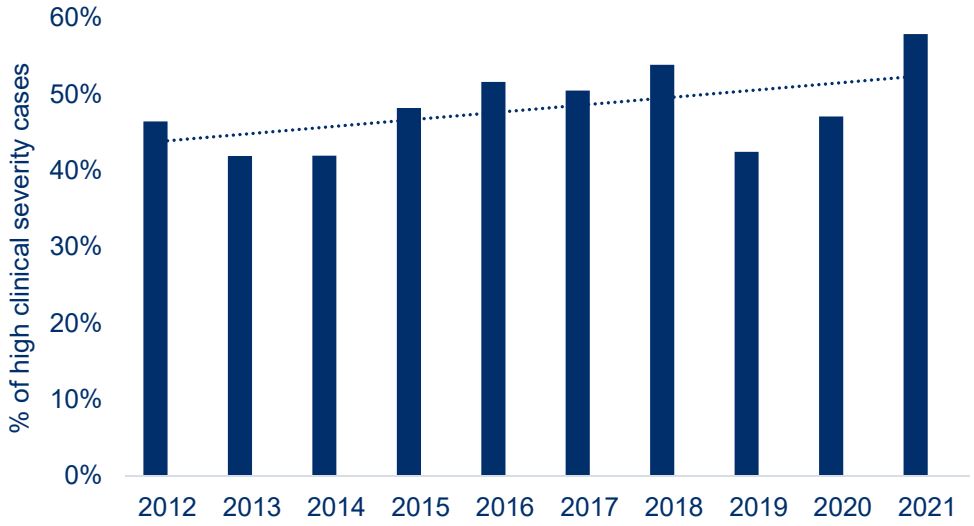


While the attending/consult physician role is most prevalent, **NPs and PAs combined are noted in 18% of all cases***. As the involvement of NPs and PAs in healthcare has continued to climb**, it is not surprising to see cases noting NPs and PAs in the primary role steadily increasing over many of the past 10 years**. The unexpected more recent decline in this data set is likely related to the fact that not all cases opened in 2020 and 2021 have yet matured for coding.

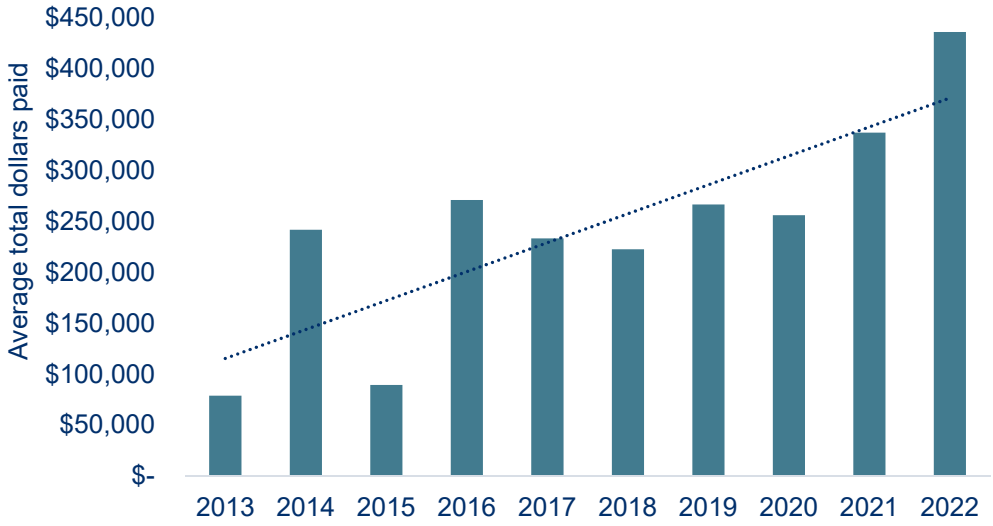
MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service role (N=1466; NP=640; PA=868; more than one role possible per case); *All cases in which a primary role is identified (N=8427; note: more than one role per case is possible)

Clinical* & Financial Severity

High clinical* severity cases by open year



High clinical severity closed cases - financial** severity by closed year

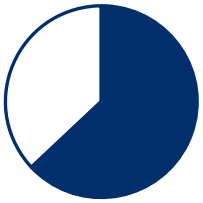


Across the years, the **percentage of cases opened each year noting a high clinical severity outcome is steadily rising**. Likewise, the **average cost to resolve** high clinical severity cases is **rapidly increasing**.

MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service role (N=1466; NP=640; PA=868; more than one role possible per case); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale (high severity N=704); **Total dollars paid = expense + indemnity (high severity closed case N=583)

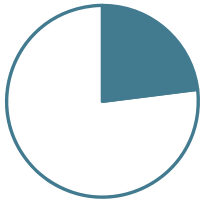
Claimant Type

Claimant type by % of overall case volume



Ambulatory
63%

43% high clinical severity*



Inpatient
23%

60% high clinical severity*

Emergency
14%

52% high clinical severity*

Claimant type by % of each role's case volume

	Ambulatory	Inpatient	Emergency
NP	65%	25%	10%
PA	62%	21%	17%

MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service role (N=1466; NP=640; PA=868; more than one role possible per case); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

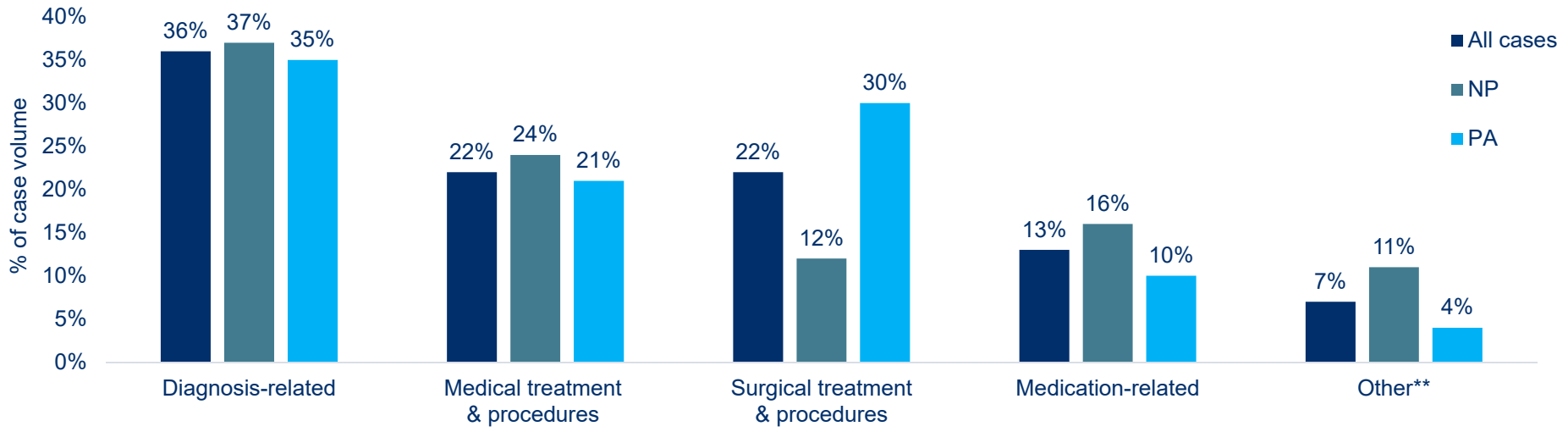
Location

Most common locations	% of all case volume	NP	PA
Office/clinic	47%	51%	45%
Emergency department/urgent care	20%	15%	23%
Patient room/ICU	11%	14%	9%
Inpatient surgery	9%	4%	12%
Ambulatory surgery	5%	4%	5%

MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service role (N=1466; NP=640; PA=868; more than one role possible per case)

Major Allegations

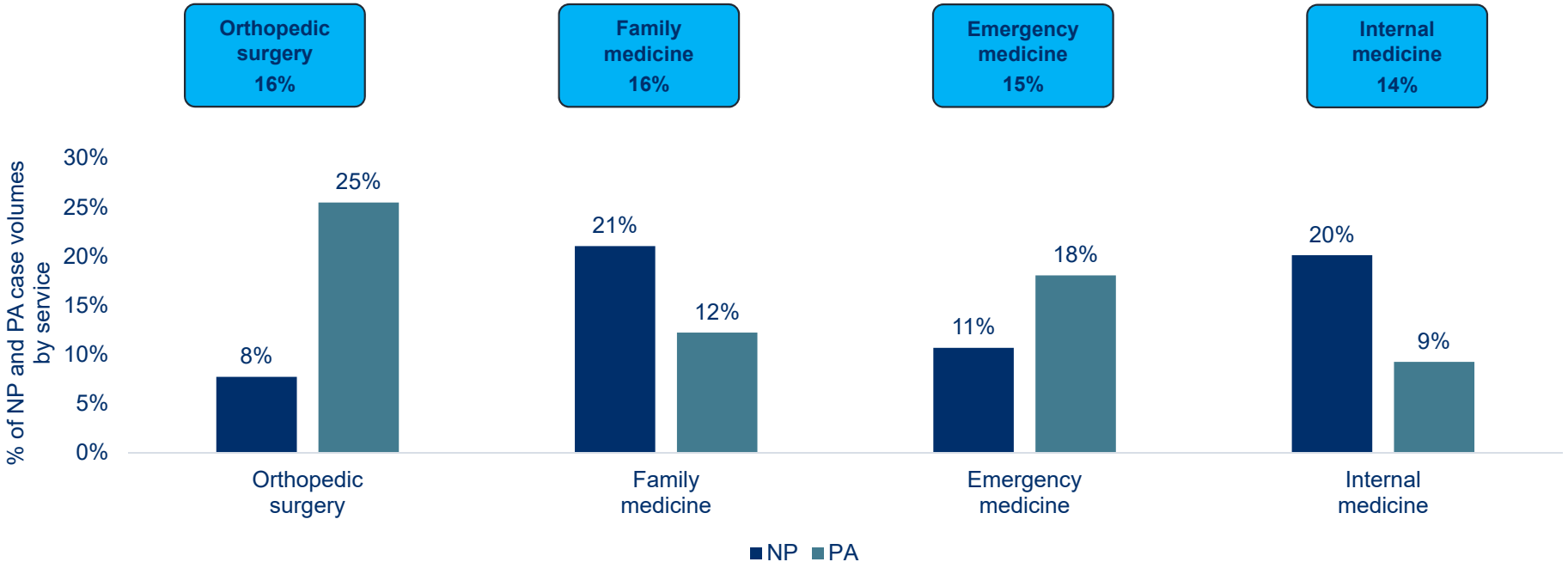
Each case reflects one major allegation category. Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts. The coding taxonomy includes **detailed allegation sub-categories; insight into these is noted later in this report.**



MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service role (N=1466; NP=640; PA=868; more than one role possible per case); *Other includes allegations for which no significant case volume exists

Primary Responsible Services

The **primary responsible service** in each case is the **specialty that is deemed to be most responsible** for the resulting patient outcome. The **four most common responsible services in cases with a NP or PA also involved are noted first**, by percentage of case volume. Then, the **distribution of NP and PA roles by their associated services** is displayed below.



CRICO/RMF Pro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service role (N=1466; NP=640; PA=868; more than one role possible per case)

Contributing Factor Focus by Claimant Type: Clinical Judgment

The same contributing factors can be seen across settings (claimant types), although there are some visible differences. All factors are also linked to roles within the case*. This visual reflects **those cases in which a CLINICAL JUDGMENT factor is specifically linked to either an NP or PA.**

Most common clinical judgment details	All claimant types	Ambulatory	Inpatient	Emergency
Failure to appreciate/reconcile relevant sign/symptom/test result	**47%**	**48%**	**52%**	**34%**
Failure/delay in ordering diagnostic test	**28%**	**32%**	**20%**	**32%**
Failure to establish differential diagnosis	**20%**	**21%**	**15%**	**23%**
Failure/delay in obtaining consult/referral	**20%**	**27%**	**12%**	**11%**
Lack of/inadequate history/physical	**18%**	**17%**	**16%**	**23%**

The prevalence of diagnosis-related allegations in this data set (36% of all cases) increases the volume of clinical judgment factors.

One additional factor stands out. **Inadequate assessment resulting in premature discharge from care is present in 32% of the Emergency claimant type cases.**

MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service role (N=1466; NP=640; PA=868; more than one role possible per case); More than one factor per case, therefore totals >100%; *Linking available for all cases coded after July 2021

Case Studies

Private equity impact

Adequate supervision

Staffing ratios – senior care facilities

Overlapping surgery

Covid

Introductory Case Examples

SETTLED

$4.3M

RESPONSIBLE SERVICE

Internal medicine (supervising specialty)

PRIMARY ROLE

Nurse practitioner

FAILURE TO DIAGNOSE STROKE

Patient's **anticoagulation regimen** was being regularly monitored every six months by his internal medicine physician; INR levels remained stable and in the therapeutic range.

On **a Sunday, the patient presented to an urgent care clinic for a headache and neck pain** (8/10 reported pain level). The **physician assistant (PA) prescribed Vicodin** and discharged the patient to home.

Two days later, the patient **returned to the same clinic with increased head and neck pain** (now 10/10). The **nurse practitioner (NP) examined him, and prescribed a muscle relaxant**. The NP's chart documentation was very poorly written; it contained no detail regarding whether a neurological exam was completed, only that the patient had "no focal deficits." No head CT was ordered, despite readily available chart reference to the patient's chronic anticoagulant use, and repeat visits for head and neck pain.

The next day, the patient was taken to the Emergency Department with a vertebral dissection and hemorrhagic stroke.

Introductory Case Examples

SETTLED

$600K

RESPONSIBLE SERVICE

General surgery (supervising specialty)

PRIMARY ROLE

Physician assistant

IMPROPER PERFORMANCE OF SURGERY AND IMPROPER MANAGEMENT OF A SURGICAL PATIENT

A general surgeon performed a laparoscopic reduction and repair of a complex para-esophageal hiatal hernia. On post-operative day one, the patient complained of left shoulder pain. Some lab results were concerning, but **no new differential diagnoses were considered**.

Discharge was planned, but the **patient stated he didn't feel ready**; he **told the surgical physician assistant (PA) that he was unable to eat or drink** (even clear liquids didn't go down smoothly).

Despite a low grade fever, belching, nausea, and newly elevated blood pressures, the patient was discharged to home three days post-operatively on pureed diet. **He died one day later**.

Autopsy revealed gastric necrosis and perforation. **Experts were critical, opining there was a deviation by both the general surgeon and the surgical PA** in prematurely discharging this patient; both failed to order imaging studies and timely intervene with placement of a nasogastric tube for decompression or surgery that **would have avoided his death**.

Case Examples

SETTLED

$750,000

CONTRIBUTING FACTORS

Clinical environment
Nights/weekends

Clinical judgment

Patient assessment – narrow diagnostic focus

Failure to appreciate and reconcile relevant sign/symptom/test result

Misinterpretation of diagnostic studies

Choice of practice setting (failure to refer to the ED)

Documentation

Lack of documentation – review of participation in care

FAILURE TO DIAGNOSIS ISCHEMIC HEART DISEASE RESULTING IN PERMANENT HEART DAMAGE

A female in her early 70's with history significant for coronary artery disease, hypertension, diverticulosis, and smoking, presented to an urgent care facility on a weekend with complaints of mild (1/10) chest pain, pressure, and a burning sensation in the right anterior chest and upper back **for the past 24 hours**. She was seen by a physician's assistant (PA).The patient stated she typically consumed "a lot of tomato juice" and that eating exacerbated her pain. She stated that antacids helped to alleviate her symptoms..

The PA's physical examination of the patient noted that she was in no acute distress, with stable vital signs. **A 12-lead echocardiogram (ECG) was interpreted as sinus rhythm with a left bundle branch h block.** The patient reported her last cardiology visit was over a year ago and her last stress test was over five years ago. She was advised to schedule a follow up with her cardiologist and to return to the urgent care facility the next day for a follow-up on the abnormal ECG. (Of note, the **facility's supervising family medicine physician did not see the patient nor sign-off on the PA's treatment until three days later.**)

That same evening, the patient's pain returned. She called 911 and then collapsed at home. When EMS arrived, they did CPR, revived the patient, and took her to the Emergency Department (ED). It was determined that she had **suffered an ST-elevation myocardial infarction (STEMI).** The patient underwent surgery, and had two stents and a defibrillator device placed, but suffered permanent, significant heart damage.

The patient claimed the permanent damage to the heart was from failing to properly read the ECG and diagnose ischemic heart disease. Experts who reviewed the ECG noted that the **PA failed to recognize concerning ST elevations on the ECG which were concerning for myocardial ischemia**. Experts also opined the **PA failed to refer the patient to the ED immediately for further cardiac evaluation.**

Risk Solutions

Increase the supply

Medical students
Residency programs (rate limiting step)
Recruitment – IMGs 24.7 %
Allied healthcare providers
Reduce turnover – address burnout, resiliency
Increase retention – transition to retirement

Increase capacity

- Artificial intelligence
- Virtual health assistants
- AI scribes
- Wearables
- Holobox

At Last, You Can Get A Healthcare 'Pod' Experience At The Gym

A healthcare tech firm has launched the 'world's first A.I. doctor's office,' which will soon be installed in gyms, malls and offices nationwide.

Newsletter sign up

(Image credit: Courtesy of Forward)

https://abcnews.go.com/Health/texas-hospital-reportedly-1st-us-holograms-doctor-patient/story?id=111435198

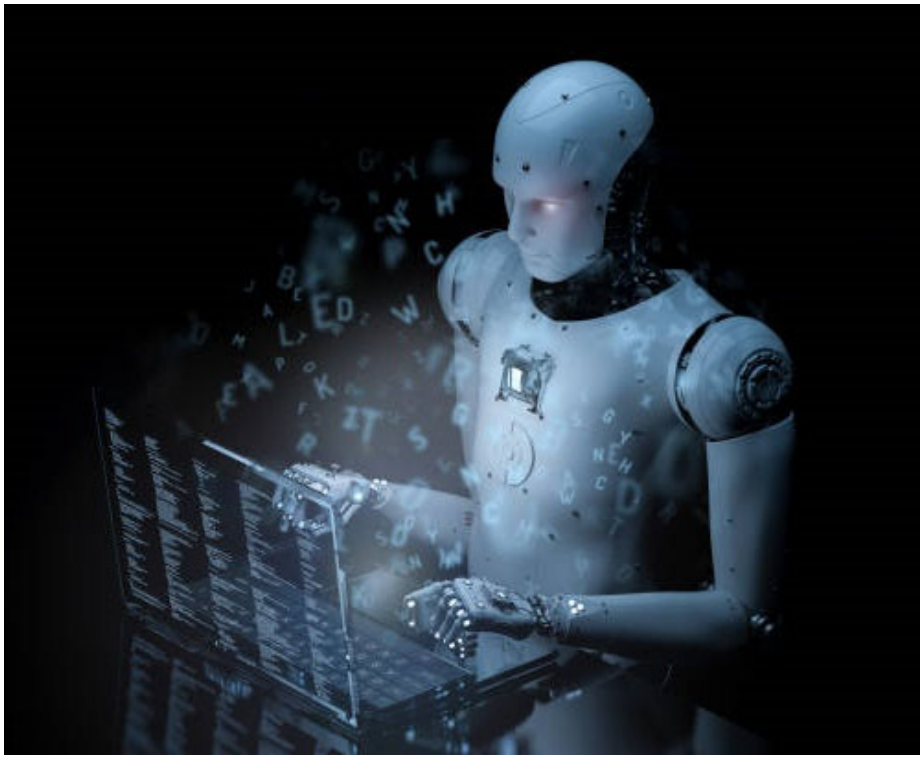
Artificial intelligence scribes

Pros:

- Increases efficiency
- Improved accuracy
- Cost effective
- 24/7 availability
- Scalability

Cons:

- Initial learning curve
- Informed Consent?
- Limited understanding of context
- Dependence on technology
- Privacy concerns
- Potential for bias
- Forensic audits and metadata
- AI self-life-requires human accuracy checks
- Ripcord strategy



The cost of technology

Think outside the box: Assistant physician

Medical school graduate, passed USMLE Step 1 and 2, but not residency

Expand the scope of non-physician practitioners

Safety

State by state variation

How much is to much?

Solutions that target retention

Increase in training and education

- Expanding training programs for healthcare professionals to include the utilization of AI

Address Burnout and Retention

- improve working conditions
- improve compensation
- peer support
- work life balance
- self scheduling
- employee engagement programs
- employee recognition programs
- increase in technology-virtual admission/discharge systems

Conclusion

Change is inevitable.

First, do no harm.

Resources

Full Report: The Complexities of Physician Supply and Demand: Projections from 2021 to 2036

Summary Report: The Complexities of Physician Supply and Demand: Projections From 2021 to 2036

U.S Physician Workforce Data Dashboard

AMMC Report on Residents

Addressing the Physician Workforce Shortage

Access more information, tools, and education

MedPro on LinkedIn

MedPro Publications

MedPro on X

MedPro Education

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