



Rheumatology: Supply, Demand and Recruiting Trends

A resource provided by Merritt Hawkins, the nation's leading physician search and consulting firm and a company of AMN Healthcare (NYSE: AMN), the largest healthcare workforce solutions company in the United States.

SUPPLY, DEMAND AND RECRUITING TRENDS IN RHEUMATOLOGY

INTRODUCTION

Merritt Hawkins is the nation's leading physician search and consulting firm and is a company of AMN Healthcare (NYSE: AMN) the largest healthcare staffing organization in the country and the innovator of healthcare workforce solutions.

As the thought leader in its field, Merritt Hawkins produces a series of surveys, white papers, speaking presentations and other resources providing insight into physician supply and demand, physician compensation, physician practice patterns, recruiting strategies and related trends.

This white paper examines trends in the recruitment of rheumatologists, including current supply and demand projections, compensation in the specialty, and recommendations for recruiting these sought-after medical professionals.

HISTORY AND DEVELOPMENT OF RHEUMATOLOGY

Unlike some other medical specialties, rheumatology cannot be defined as a specialty treating diseases of a particular organ, such as the heart or lungs. Instead, it is a medical specialty devoted to the diagnosis and management of over **100** diseases. It focuses on the treatment of inflammation in the bones, muscles, joints and internal organs, including the kidneys, lungs, blood vessels and the brain.

The treatment of some of these maladies can be traced to antiquity. Inflammatory diseases such as gout and osteoarthritis have been common for thousands of years. According to one scholarly article, "Examination of 400 Saxon, Romano-British and mediaeval skeletons from seven archaeological excavations in the west of England showed changes suggestive of arthritis, osteoarthritis and osteophytosis. Changes suggestive of ankylosing spondylitis were found in the 3000-year-old Egyptian mummy of Ramses II. Two skeletons of ancient Egyptians dated to about 1500 BC show radiological signs suggestive of ankylosing spondylosis. Egyptians first identified gout, known as podagra, in 2640 BC." (*Deshpande S. History of Rheumatology. Med J DY Patil Univ.*)

The term "rheumatism" was coined by Guillaume de Baillou (1538-1616), a French physician, in his *Book on Rheumatism and Back Pain* and he is consequently considered the father of rheumatology.

PROGRESS OF RHEUMATOLOGY IN THE 20TH CENTURY

Advances in the treatment of rheumatology proceeded into modern times, and in 1940 American physicians Bernard Comroe and Joseph Lee Hollander originated the term "rheumatologist."

Rheumatology has rapidly advanced during the last 50 years due to improved diagnosis as a result of progress in immunology, molecular biology, genetics and imaging. Disease-specific criteria have been developed for the majority of rheumatic diseases during the last 50 years to keep uniformity in diagnosis and classification.

Various assessment scales and indices such as the Health Assessment Questionnaire (HAQ), DAS-28 and SLEDAI have been developed in the last 25 years. These help clinicians to objectively assess the severity and response to treatment and help

clinicians to modify the treatment. The HAQ, published in 1980, was among the first instruments based on generic, patient-centered dimensions to assess the severity of rheumatoid arthritis (RA). It was originally developed in 1978 by James F Fries, MD, and colleagues at Stanford University.

The American College of Rheumatology (ARC) has developed the ACR success criteria, referred to commonly as ACR 20/50/70, to assess improvements in outcomes such as pain, disease activity and physical activity as assessed by patients, the physician's global assessment of disease activity and acute phase reactant in RA. The 20, 50 or 70 designations refer to improvements in percentage terms to 20%, 50% or 70% in the relevant dimensions. The ACR criteria have immensely helped in shifting the entire focus to patient-related outcomes.

Advances in molecular biology have helped in better understanding of the disease process as well as finding new therapeutic targets such as inflammatory mediators.

SCOPE AND DUTIES OF RHEUMATOLOGISTS

According to the ARC, "A rheumatologist is an internist or pediatrician who received further training in the diagnosis and treatment of musculoskeletal disease and systemic autoimmune conditions commonly referred to as rheumatic diseases. These diseases can affect the joints, muscles, and bones, causing pain, swelling, stiffness, and deformity."

Autoimmune ailments take place when the immune system sends inflammation to areas of the body when it is not needed, causing damage or generating symptoms in the musculoskeletal system. Rheumatologists treat joint ailments similar to those treated by orthopedists but do not perform surgeries. These ailments can also affect the eyes, skin, nervous system, and internal organs, which rheumatologists also treat.

Common diseases treated by rheumatologists include osteoarthritis, gout, rheumatoid arthritis, chronic back pain, tendinitis, and lupus. Many rheumatologists also conduct research to find a cause of and better treatment of a rheumatic disease.

Rheumatologists care for a wide array of patients—from children to the elderly. A central part of their role is to manage the care of rheumatic diseases to ensure patients have the best possible quality of life.

Because these diseases are often complex, they benefit from the care of an expert. Only rheumatologists are experts in this field of medicine.

According to the ARC, rheumatologists assess:

- Signs and symptoms, including systemic effects of a rheumatic disease

- Joint disorders
- Overall patient function, including physical well-being, mental well-being and level of independence
- Results of advanced imaging and lab tests
- Need for more assessment and treatment, such as
 - referrals to other health care providers
 - orthopedic aids (splint, brace, cane, etc.) or corrective surgery
 - hospital stays

The ARC notes that "Rheumatologists also advocate for the patient in all aspects of health care and in the community. As a group, these doctors support laws that promote patient rights and patient-centered care. The rheumatologist teaches the patient, family and community about health information and how to live with a chronic rheumatic disease. Topics can include medications, coping mechanisms, techniques for preventing disability or regaining function, and ways to improve quality of life."

Rheumatic diseases are sometimes complex in nature and difficult to diagnose, so rheumatologists will gather a complete medical history and perform a physical exam to look for signs and symptoms of inflammation throughout the entire body and musculoskeletal system.

The rheumatologist will review the results of any prior testing that has been performed on a patient and may order additional laboratory tests to assess inflammation and/or extra antibody

production within the bloodstream and order radiographic testing (X-ray, ultrasound, CT scan or MRI) to assess for musculoskeletal abnormalities.

All of these results will be combined to determine the source of a patient's symptoms and develop a personalized treatment plan. Treatment recommendations may include medications, referral to physical therapy, referral to other specialists, or joint/

tendon injections. Some rheumatic diseases can be difficult to diagnose and may require several visits for the rheumatologist to fully understand the underlying process.

During follow-up appointments, rheumatologists may treat reoccurring conditions or talk with patients about medications, coping mechanisms, techniques for preventing disability or regaining function, and ways to improve their quality of life.

ROLES IN RHEUMATOLOGY

Rheumatologists may serve in a number of roles. According to the ARC, these include:

CLINICAL INVESTIGATOR

A rheumatology clinical investigator engages in research relevant to rheumatic diseases. A clinical investigator is responsible for making sure a clinical trial meets all research expectations, regulatory requirements and protects the rights and welfare of human participants.

CLINICAL EDUCATOR

Clinical educators provide clinical education to future rheumatologists in academic/residency settings.

CLINICAL PRACTICE

Many rheumatologists focus on patient care in various settings, generally in outpatient clinics, where they may be a solo practice owner, or in a physician-owned medical group, a hospital-owned medical group or a hospital employee.

SCIENCE RESEARCHER

Rheumatologists working as basic science researchers study rheumatoid diseases in a laboratory, generally at the molecular or cellular level.

TRANSLATIONAL RESEARCHERS

Translational researchers analyze discoveries generated during research in the laboratory and determine the impact on human health. Translational researchers then develop preventive and treatment strategies and practice guidelines. Translational research in rheumatic diseases is expanding rapidly with new findings about the genetic factors that influence disease susceptibility and severity.

PEDIATRIC RHEUMATOLOGY

Pediatric rheumatologists specialize in providing comprehensive care to children with rheumatic diseases.

PHARMACEUTICAL INDUSTRY

Rheumatologists in pharmaceutical careers work with various teams, including clinical operations, regulatory affairs, legal affairs, research groups and commercial departments to develop and test drugs.

EDUCATION AND TRAINING

The path to becoming a rheumatologist includes four years of allopathic or osteopathic medical school, three years of internal medicine or pediatrics training, and two to three years of a rheumatology fellowship. Some rheumatologists are trained in both internal medicine and pediatrics.

After completing their rheumatology fellowship training, they must pass a rigorous national exam. For adult rheumatologists, the subspecialty exam is conducted by the American Board of Internal Medicine. For pediatric rheumatologists, the American Board of Pediatrics conducts the exam. A certification/exam has to be retaken every ten years. Rheumatologists are also required to participate in a certain amount of continuing medical education on a yearly basis.

Dual certification in both rheumatology and allergy and immunology also is available and requires a minimum of three years of training beyond the three year basic internal medicine residency. Completion of this combined fellowship allows for board certification in both rheumatology and allergy and immunology.

RHEUMATOLOGY SUPPLY AND DEMAND TRENDS

Rheumatology is one of a variety of specialties for which there is a rising demand in the U.S. and a limited supply (for more information on this topic, see Merritt Hawkins' white paper *Physician Supply Considerations: The Emerging Shortage of Specialists*).

In its June 2021 report, the Association of American Medical Colleges (AAMC) projected a shortage of up to 124,000 physicians nationally by 2034. This will include a shortage of more than 47,000 primary care physicians, but an even larger shortage of up to 77,100 specialists (*The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Association of American Medical Colleges. June 2021*).

In an online article posted by The Arthritis Foundation, Daniel F. Battafarano, DO, division director, Rheumatology Service at the San Antonio Military Center was cited as follows:

"In 10 years, we will have a significant challenge in America to take care of the demands of rheumatology care. Every region in the U.S. will be negatively affected by [having] far less rheumatologists than we think will be optimal.," (Davis, Jennifer. *Growing Shortage of Rheumatologists "Very Concerning."* Arthritis Foundation. Feb. 20, 2018)

Dr. Battafarano was the lead author of one article and senior author of a second article published in 2018 in *Arthritis & Rheumatology and Arthritis Care & Research*, respectively. Both examined the future of the rheumatology workforce in the U.S. Dr. Battafarano and other researchers projected in these articles that by 2030, the rheumatology workforce — including physicians, physician assistants (PAs) and nurse practitioners (NPs) — would be only half of what they considered optimal. They attribute this shortage mostly to a growing and aging population, which they project will increase demand for rheumatology services somewhere between 25 to 50 percent.

The analyses in the articles point to several factors that will drive the shortage, including:

- **Retirement.** 50 percent of rheumatologists say they plan to retire in the next 10 years, according to the articles.
- **A limited number of new rheumatologists:** Too few residents are coming out annually to replace those who will exit the workforce.
- **Changing workforce practice patterns.** According to the Arthritis Foundation article, the number of female rheumatologists will grow from over 40 percent to 67 percent by 2030. The article notes that "Prior studies have shown that women work 7 fewer hours per week and see 30 percent fewer patients per year than men. Millennials, born 1982-2004, make up 6 percent of the current workforce but their ranks will grow to 44 percent of the workforce by 2030. Millennials in 2015 saw fewer patients compared to their counterparts in 2005."
- **Maldistribution:** Most rheumatologists work in urban and suburban areas, leaving much of the country under-served. For example, 21 percent of adult rheumatologists were located in the Northeast in 2015, with only 3.9 percent in the Southwest.

By 2040, the number of U.S. adults diagnosed with arthritis is projected to increase by 49%, to 78.4 million. Other rheumatic diseases will also increase in prevalence due to aging of the baby boomer generation and increasing life expectancy. At the same time, a significant shortfall in the adult rheumatology workforce is anticipated. (Hootman J.M., Helmick C.G., Barbour K.E., Theis K.A., Boring M.A. *Updated projected prevalence of self-reported doctor-diagnosed arthritis and arthritis-attributable activity limitation among US adults, 2015-2040. Arthritis Rheumatol (Hoboken, NJ) 2016;68(7):1582–1587. doi: 10.1002/art.39692.*)

A 2015 American College of Rheumatology Workforce Study projected that by 2030 adult rheumatology providers (physicians, nurse practitioners and physician assistants), will decline by 25%, in terms of full time equivalents (FTEs), resulting in demand exceeding the supply of rheumatology providers by 102%. (Battafarano D.F., Ditmyer M., Bolster M.B. *American college of rheumatology workforce study: supply and demand projections of adult rheumatology workforce (2015-2030) Arthritis Care Res (Hoboken) 2015 doi: 10.1002/acr.23518. February 2018.*)

In a 2016 study, the Health Resources and Services Administration (HRSA) projected there will be 280 too few rheumatologists by 2025.

EFFECT OF TELEMEDICINE

Telemedicine was widely adopted during Covid-19 by many types of doctors, including rheumatologists. According to the 2020 *Survey of America's Physicians*, conducted by Merritt Hawkins on behalf of The Physicians Foundation, 12% of physicians switched to a primarily telemedicine practice as a result of the pandemic. Through efficiency gains, telemedicine could be one method by which the rheumatology workforce could be extended, helping to alleviate shortages.

While telemedicine holds promise to improve access to care, particularly in underserved communities, legal, regulatory and reimbursement issues will need to be addressed before physicians adopt telemedicine for the long-term.

According to the *Survey of America's Physicians*, 72% of physicians agree that the widespread use of telemedicine will not continue unless reimbursement for telemedicine and in-person visits remain comparable.

AN AGING RHEUMATOLOGY WORKFORCE

Close to half of physicians in the U.S. are 55 years old or older, and a wave of physician retirements is imminent. Many rheumatologists are in this category. Forty-six percent are 55 years old or older, (see chart below):

SPECIALTIES	PERCENT OF PHYSICIANS 55 OR OLDER
Pulmonology	73%
Psychiatry	60%
Cardiology (Non-Inv.)	54%
Orthopedic Surgery	52%
Urology	48%
Ophthalmology	48%
General Surgery	48%
Rheumatology	46%
Gastroenterology	45%
Anesthesiology	44%
Internal Medicine	40%
Family Practice	38%
Pediatrics	38%

Source: American Medical Association Physician Master File

COMPOSITION OF THE RHEUMATOLOGY WORKFORCE

The charts below indicates the current composition of the rheumatology workforce:

RHEUMATOLOGY SPECIALTY DEMOGRAPHICS	
Total	6,240 (as of 2019)
In full-time, active	4,945
Board Certified	4,701 (95% of those active)
International medical graduates	1,740 (35%)
Administrative/teaching	157 (3%)

RHEUMATOLOGY SPECIALTY DEMOGRAPHICS

Research	235 (5%)
Last year residents	204 (4%)
Female	2,215 (45%)
Male	2,730 (55%)
45 or older	3,467 (70%)
55 or older	2,253 (46%)

Source: American Medical Association Physician Master File

As these numbers indicate, a comparatively high number of rheumatologists are international medical graduates (IMGs) – 35% compared to approximately 25% of all physicians. In addition, a comparatively high number are female – 45% compared to approximately 35% of all physicians. The supply of new rheumatologists remains limited, with about 200 completing their training and joining the workforce each year.

SUGGESTED RATIO OF RHEUMATOLOGISTS REQUIRED PER 100,000 PEOPLE

Given the current supply situation, many communities do not have the number of rheumatologists per capita recommended by various sources.

Richard Cooper, M.D./University of Pennsylvania	1.5
Solucient	1.3
Hicks & Glenn	0.7

USE OF PAs AND NPs

Advanced practice professionals such as physician assistants (PAs) and nurse practitioners (NPs) may be able to absorb some of the duties of rheumatologists and reduce shortages.

According to Medscape's *2020 Physician Compensation Report*, 21% of rheumatologists work with PAs in their practices and 30% work with NPs, while 37% work with neither.

EFFECT OF THE GME SPENDING CAP

The likelihood that additional rheumatologists will be trained, and the number of new entrants increased, is limited due to the 1997 cap Congress placed on funding for physician graduate medical education (GME). The cap was lifted in 2020 as a provision of the Covid-19 relief bill, but funding was only added for 1,000 additional residencies across all specialties. Many of these will likely be reserved for primary care and very few for rheumatology.

COMPENSATION IN RHEUMATOLOGY

In its annual *Review of Physician and Advanced Practitioner Recruiting Incentives*, Merritt Hawkins tracks the starting salaries, signing bonuses and other incentives offered by our clients when recruiting physicians in various specialties. Below are low, average and high starting salaries for rheumatology:

STARTING SALARIES IN RHEUMATOLOGY		
LOW	MEDIUM	HIGH
\$220,000	\$260,000	\$600,000

Various sources track compensation/average income for rheumatologists and other physicians. Data from some of these sources are cited below:

SOURCE	AVERAGE COMPENSATION/RHEUMATOLOGY
Medical Group Management Association	\$381,271
Merritt Hawkins	\$260,000
Medscape	\$276,000

It should be stressed that Merritt Hawkins' data differs from other sources cited above in that we report starting salaries offered to rheumatologists and other physicians, rather than total pre-tax annual compensation.

RECRUITING RECOMMENDATIONS

As demand for rheumatologists increases, so will the difficulty of recruiting these specialists. Hospitals, medical groups and other healthcare facilities that are seeking rheumatologists should prepare to commit the required effort, flexibility, responsiveness and resources required to be successful in today's challenging market.

The key, as with all physician searches, is to make the practice environment as appealing as possible. Hospitals, medical groups and other facilities seeking rheumatologists have no control over their geographic location, the number of cultural or educational options in their communities, or related quality of life amenities. However, they can to a significant extent control the quality of practice being offered.

What rheumatology candidates find appealing in a practice will vary, but there are some general guidelines to follow.

The majority of rheumatology candidates are looking for practices that offer a controllable lifestyle featuring time for family activities, hobbies, travel, etc. Many rheumatologists Merritt Hawkins speaks with seek a three to four-day work week, and the great majority are only interested in a 100% outpatient practice.

Patient volumes vary, but it is fairly typical for rheumatologists to work an eight-hour day and see between 16-18 patients a day, on average. Some rheumatologists who practice in typically underserved communities where patients often have multiple chronic illnesses are more likely to see 14-15 patient per day, on average, spending relatively more time per patient.

There are exceptions to these averages, including rheumatologists who still are in private practice and may need or want to see higher volumes to stay ahead of costs or who may be more entrepreneurial in outlook than employed rheumatologists.

However, a lucrative practice potential is not necessarily the key to recruiting success in today's rheumatology market. Merritt Hawkins recently worked in a Texas community where the practice could demonstrate a \$500,000 annual potential. Nevertheless, this search engagement was challenging given its non-metropolitan location. Virtually every younger rheumatology candidate Merritt Hawkins interviews expresses a preference for a major metro area or other restrictive geographic preference.

CANDIDATE PARAMETERS

For this reason, flexibility is advisable when it comes to considering candidate parameters. Be open to international medical graduates (IMGs) and candidates of all ages if they display the competence, training and patient rapport you are seeking. A relatively high number of rheumatologists (35%) are IMGs and by not considering them, hospitals and medical groups greatly reduce their choice of qualified candidates. Due to work visa and green card requirements, these candidates may be more open to a variety of geographic settings.

As was referenced above, many rheumatologists are 55 or older, but the appropriate candidate may not be one of a particular age. Rather, he or she may simply be a physician with the requisite skills who wants to practice in your community, so age should not be a primary consideration. It also is important to consider MD and DO candidates equally and male and female candidates equally.

ADDITIONAL FEATURES OF A POSITIVE RHEUMATOLOGY PRACTICE

Other features of a rheumatology practice likely to attract candidates include:

- Multiple ancillary services in-house under one roof, including an infusion suite, digital x-ray, bone densitometry, MSK ultrasound, pharmacy, lab, etc.
- Shared compensation for infusions.
- Strong referral network with primary care and other related specialists, such as orthopedic surgeons.
- Access to pediatric rheumatologists.
- Ability to expand beyond patient care. Rheumatology is a considered a cerebral/academic specialty. Many candidates will be accustomed to participating in clinical trials. The ability to offer this aspect of the specialty, with adequate staff/support, will be attractive.
- Consider whether or not MSK ultrasound certification is a necessary requirement.
- Provide rheumatologists with control over their schedules. For example, many rheumatology practices have a 20/40 or 15/30 policy whereby the physicians sees recurring patients for the shorter amount of time and new patients for the longer amount of time. However, sometimes patients require a longer amount of time during their appointment than what was initially scheduled. Rheumatologists should be given discretion to determine what is best in each instance, and not have this decision dictated to them.
- Favorable ratios of physicians to medical assistants (MAs) and nurses. A one rheumatologist to one MA and to one nurse is the ideal ratio. Practically, two rheumatologists sharing one MA and one nurse is more common and still considered favorable. This allows physicians to spend less time on administrative responsibilities and achieve a better work/life balance. It often also allows them to earn a better income. Rheumatologists may be on a guaranteed salary for 1-2 years, which then may convert to either 100% productivity or a salary with a productivity bonus structure. Often, there is no compensation for the amount of time they spend doing administrative tasks, which could account for more than 20 hours a week. Being able to focus mostly on patient care is therefore a major attraction to rheumatologists and virtually all other physicians.
- Allow rheumatologists to decide for themselves if they are willing to respond to patients via email regarding their questions, as opposed to the patient having to come to the office for a visit. Several Merritt Hawkins clients allow one work day (or a half day) to be dedicated to remote/virtual care, and that has proven to be extremely attractive to some candidates when given the option to work a day from home.
- Where possible, offer a 100% rheumatology practice. Many practices require rheumatologists to practice some form of internal medicine or be on-call for internal medicine. A 100% rheumatology practice therefore is a major draw for many candidates. Some candidates prefer a multispecialty clinic as this allows them to practice 100% rheumatology. Having colleagues in other specialties also allow rheumatologists to discuss cases that go beyond the scope of rheumatology.
- Physician-friendly electronic health records (EHR).
- Availability of NPs and PAs.
- Covid-19 safety protocols/PPE availability.
- Minimum possible paperwork duties, maximum patient consultation time.
- Fair, understandable productivity measures.
- Contract/incentive flexibility that may offer:
 - Residency stipends
 - Student loan repayment
 - Sign-on bonus, retention bonus
 - Accelerated partnership track

A BUYER'S MARKET

Another general rule of thumb in recruiting rheumatologists is not to underestimate how many practice options rheumatologists generally have to choose from. With fewer than 5,000 rheumatologists in active patient care nationwide, there is a very small candidate pool of physicians seeking a practice. Most rheumatology candidates have multiple options to choose from, even within their own state.

Hospitals, medical groups and other facilities therefore must be flexible and creative when recruiting rheumatologists, adjusting schedules to accommodate their needs, where possible, offering competitive signing bonuses in the \$40,000 to \$50,000 range, and offering telemedicine/work from home options.

Compensation should be competitive. Experienced rheumatologists can command a salary of \$300,000 to \$325,000 or more, plus production bonus. Graduating residents typically start at approximately \$250,000, plus productivity bonus. Private rheumatology practice owners can earn well over \$700,000 in the ideal environment with all ancillary services in-house.

CONCLUSION

As with all difficult searches, it is important in rheumatology searches to be flexible, creative, and committed to quick turnarounds, accommodating the schedules of candidates, responding with information as needed, and making an offer as soon as an appropriate candidate is found. Know the market, know what is needed to be successful, and execute the search with the maximum amount of commitment and efficiency as possible.

ABOUT MERRITT HAWKINS

Established in 1987, Merritt Hawkins is the leading physician search and consulting firm in the United States and is a company of AMN Healthcare (NYSE: AMN), the largest healthcare workforce solutions organization in the nation. Merritt Hawkins' provides physician and advanced practitioner recruiting services to hospitals, medical groups, community health centers, telehealth providers and many other types of entities nationwide.

The thought leader in our industry, Merritt Hawkins produces a series of surveys, white papers, books, and speaking presentations internally and also produces research and thought leadership for third parties. Organizations for which Merritt Hawkins has completed research and analysis projects include **The Physicians Foundation, the Indian Health Service, Trinity University, the American Academy of Physician Assistants, the Association of Academic Surgical Administrators, The Maryland Medical Society, and the North Texas Regional Extension Center.**

This is one in a series of Merritt Hawkins' white papers examining a variety of topics directly or indirectly affecting the recruitment and retention of physicians and advanced practice professionals, including physician assistants (PAs) and nurse practitioner (NPs).

Additional Merritt Hawkins' white papers include:

- Supply, Demand and Recruiting Trends in Family Medicine
- Ten Keys to Enhancing Physician/Hospital Relations: A Guide for Hospital Leaders
- Rural Physician Recruiting Challenges and Solutions
- Psychiatry: "The Silent Shortage"
- Nurse Practitioners and Physician Assistants: Supply, Distribution, and Scope of Practice Considerations
- The Physician Shortage: Data Points and State Rankings
- Physician Supply Considerations: The Emerging Shortage of Medical Specialists
- Supply, Demand and Recruiting Trends in Internal Medicine
- The Economic Impact of Physicians
- Will There Be a Doctor in the House? Physician Supply, Demand in the Era of COVID-19
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