

David Burda:

Welcome to the 4sight Health Roundup podcast, 4sight Health's podcast series for healthcare revolutionaries. Outcomes matter, customers count, and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, March 5th. In like a lion, out like a lamb, right? We'll see. We're gonna take a step back on today's show and catch up on some big healthcare market news from December that I think a lot of people missed. Record medical school enrollment. That's right. The number of people currently enrolled in medical school is at an all-time high. Why and what does that mean? I don't know. But I know two people who do. Dave Johnson, founder and CEO of 4sight Health, and Julie Murchinson, partner at Transformation Capital. Hi, Dave. Hi, Julie. How are you two doing this morning? Dave?

David W. Johnson:

Well, it feels to me like March the 5th should be a quirky date, like May the 4th be with you or- <laugh> ... Hi day March 14th. You know, you got Beethoven's 5th and Fifth Third and Fifth Amendment and fifth grade. I'm trying to make it work, but I can't. So I guess I'm perplexed today. Yeah. March the 5th.

Burda:

Go fourth. Yeah. Well, maybe we'll start a hashtag and see what happens online. <Laugh> All right. Thanks, Dave. Julie, how are you?

Julie Murchinson:

Well, I've made my way across the country this week from the SF AI bros to the East Coast incumbents, and it's been a bit of whiplash, but I'll say I'm, I'm seeing strangely more alignment than I think I've maybe ever seen in years, so it's kind of exciting.

Burda:

Hmm. All right. Moving in the right direction. That, that's great. Okay. Before we talk about medical school enrollment, let's talk about your experiences with doctors who are younger than you. And that may apply only to two of us. We'll see. <Laugh> , Dave, do you remember the first time you saw a doctor who was younger than you? Did it throw you or were you cool with it? ,

Johnson:

I think it was Doogie Houser, Dave. <Laugh> , I actually, I actually don't. I mean, it's been so long since I've had a doctor that was older than I was I really don't. But I can tell you the first time I was thrown by seeing someone who was a doctor was, a fraternity brother of mine named Ramon Garcia, who today is a very highly respected internist here in Chicago. But back in college when we were in the rack room together, that guy slept without sheets. I mean, when I heard he was a doctor, I ... So Ramon, you've come a long way.

Burda:

Alright. All hail Dr. Garcia, <Laugh> Thanks, Dave. Julie, you're younger than me and Dave. Have you ever seen a doctor younger than you? And if you have, what was that moment like?

Murchinson:

Well, , my first time was definitely when I hit one medical, and my doctor was not only younger than me, but was dressed in regular clothes, no white coat, talking about her vacation. So it was the first time I realized that doctors were real people.

Burda:

<Laugh> <laugh> That's great. You know, for me, it was when I finally switched my primary care doctors a few years ago. My original PCP was older than me, and he finally retired about 10 years ago. He was the one who always told me to lose weight and stop smoking no matter why

I went to see him. <Laugh> Yeah, those were his two treatment no matter what. And each time I would tell him I never smoked, and he would just say, "Lose weight." And he never, never prescribed me any medicine. He was a minimalist. And then I switched to a new PCP who, if she was 30 at the time, I'd be shocked, but she's terrific and actually listens to what I say, and she knows I don't smoke. Okay, let's talk about these enrollment figures released in December by the Association of American Medical Colleges. The AAMC represents all 163 medical schools in the US. These stats are for the 2025-2026 school year. Obviously, we're in the second half of that right now. The AAMC said total med school enrollment rose 1.3% to a record 100,723. Total med school applicants rose 5.3% to 54,699. That follows three consecutive years of declines in medical school applicants. The number of first-time applicants rose 8.4% to 41,830. The number of first year enrollees rose 1.2% to 23,440. 55% of first-year enrollees were female, as were 55% of total enrollment. And the percentage of first-year enrollees who self-identified as white dropped below 50% for the first time at 47.3%. That percentage has been declining steadily. If you look at these numbers, they tell me a lot of people still wanna be doctors. Dave, what did these numbers tell you, vis-a-vis the state of the healthcare workforce in the current and future healthcare system? What effect will AI have on the interest by people and becoming doctors? So is AI attracting new types of people to medicine?

Johnson:

You know, to tell you the truth I'm not sure what these numbers are saying about the state of the healthcare workforce, other than there are more medical students today than there have ever been before. How's that for a blinding insight? You know, bottom up, why are more people going to medical school? You know, I went to college like you in the '70s and, it was tough economic times, you know, with the oil embargoes and stagflation and all that stuff. A lot of economic uncertainty. Pretty much, everybody I knew at that time that was going

to medical school, largely for economic reasons. It was the way to punch your ticket to the, to the good life. And as I think back about those people, I don't think I'd let any of them touch me with a 10-foot pole, including Ramon, although he's really come a long way. So, we have a lot of economic uncertainty right now. If you're a young person and trying to pick a profession that you believe will be durable and, allow you to be a, you know, significant contributor to society and lead a good life, maybe medicine feels like a safe bet. So I do think there are some of those pressures. I'm just impressed by the diversity of people in medical school today and every which way you, you slice it, it looks like the American population. I think that's a very good thing. And many of these people start out idealistic, but honestly, something happens to them in the course of their medical training. You know, they come out at the other end after for four years, loaded with debt and wanting to be dermatologists, right?

Burda:

Right, right.

Johnson:

And sort of buying into the system. So, I'll come back to training and AI here in a second; but how confident should these medical students be that, the healthcare workforce is gonna need them forever? I don't believe the shortage numbers at all. They are based on a belief that the future of medical practice will mirror its past that, you know, tomorrow will be like today. Let's hope not. As I think we mentioned last week, the Cleveland Clinic is developing a \$10 AI-driven primary care visit, and that will probably be better than any primary care care visit the three of us have ever had with any doctor, Dave, including your doctor who listens well. It's gonna be informed by all of the data. They'll have the right tests, and a person will come into the equation at one time, but the first screen will be by the machine. And then, you know, that also just ... And this comes up so often in medicine, we have such a mismatch

between the needs of the people and the resources we dedicate. Even though we spend so much on healthcare, we really don't, haven't provided the foundation in public health for healthy communities, managing chronic disease, giving people the knowledge to eat better, exercise more, and so on. You know, all good strategy marry objectives with means. What exactly are objectives in healthcare? And, we certainly have means, but are we matching our resources to those objectives? What are we doing with medical students? I mean, the, the model is still largely the same as it was 100 years ago, two years of science, two years of rotations, followed by residency, and then if you're a specialist followed by a fellowship. You know, RFK is twisting the arm of all the medical schools in the country, essentially demanding that they put more nutrition education into the curriculum, you know, 25 plus hours over, over the four years. Is that really ever gonna do anything? You know, I don't know. Probably doctors should know more about nutrition than they do, but do I really care if my surgeon is an expert on nutrition? Not really. I just <laugh> want a surgeon that can do a procedure the right way. So I kinda look at all of this and say our bigger issue is to get better balance between health and healthcare. And, you know, in the book, Paul and I said that the disruptive innovation that was going to transform the industry was 3D-WPH, democratized and decentralized distribution of whole person health. One place that has really taken that to heart is AdventHealth under Terry Shaw. And part of what Terry did was they embraced whole person health and they spun off all of their frontline primary care activities into a separate division, separate funding and so on. They eliminated the nature of most primary care practices and health systems as referral centers to specialty care. And they've also made huge investments in their app and consumerism and so on. And there's a reason their market share is growing, they're as profitable as they are. But at its heart, they're marrying their objectives with their means, right? If we want a healthier society, we have to create mechanisms that, that promote that. You touched on AI and it's impossible to talk about anything these days without AI, in fact, I read yesterday that, in February, over 90% of the VC money went into AI

funded companies. And truly, that's probably something you're seeing in a big way. And I just wonder in medical school, if we're teaching this next generation of doctors how to work with the machines, because I'm convinced the machines won't replace the doctors, but doctors who know how to work with the machines will replace those who don't. And, you know, so I'm ending this the same way I started with a whole lot more questions than answers, and I just don't believe our current way of doing this is working at all. So we need to overhaul it. How we overhaul it is, what we talk about every week, so ...

Burda:

Yeah. You know, you mentioned \$10 for a primary care visit. You know, I pay more than that if I go out to lunch at Chipotle, right? <Laugh> Yeah. For burrito chips and a soda, right? <Laugh> So now, as a consumer, I'm like, "Do I do that or do I go find out if I'm sick or not?" That's-

Johnson:

By the way, your primary care doctor won't like that chips and soda part of you.

Murchinson:

Yeah, I was just gonna say the same thing.

Burda:

<Laugh> Yeah, I'll have to trim that down. That's great. Thanks, Dave. Julie, any questions for Dave?

Murchinson:

Do you think there are any healthcare specific changes we could make that would be more powerful than the upstream changes that aren't actually considered in healthcare? Like the things we talk about all the time, payment, staffing ratios, tech AI, the way we design facilities, like,

could, could the ways that we wanna turn things around from the inside really turn those EDs from the combat zones to human workplaces, or do we need to go upstream?

Johnson:

You and I are both addicted to The Pit, aren't we?

Murchinson:

Yes. <laugh>

Johnson:

It really does. That show is incredible because it's really where American society <laugh> comes into direct contact with, with the medical system. It's hard to watch a lot of the time. These very, very dedicated people completely over their heads, and pulling a rabbit out of the hat more often than you could ever imagine, but at the same time, just dealing with the stress and the harassment of working in that type of environment. Not to mention the administrators coming down and saying, "You gotta spend more time on coding, make sure you get those billables up, get people discharged earlier, even though there's no place to send them." Julie, I don't think there are magic bullets here or piecemeal solutions. The whole thing has to change. And I think it primarily means getting the incentives right. So payment that you mentioned at the beginning is really important. And the two things I hang my hat on, as you know, are value and consumerism and user experience. So, you know, what Terry Shaw was doing at Advent, which I mentioned a little bit, was very much focused on how do we serve the needs of our, our customers. And he was telling me... I talked to him this week, and he was telling me that the net promoter scores on the Advent app are in the '90s. You know, typical scores are in the '60s and '70s for health systems, and he said that their app and their focus on end users is allowing them to completely take over and dominate markets. You know, they're building that kind of customer loyalty. So I think it's

a growth strategy. It's just ... I can count on one hand the number of health systems that have fully embraced that belief that, at the end of the day, we gotta serve the people, our end users and solve their jobs to be in health and healthcare, but the places that do do that will lead the transformation. And all the other things that you're talking about will follow. We'll marry, as I said earlier, we'll marry objectives with means and we'll get much better outcomes.

Burda:

Julie, it's your turn. What's your market take on these numbers from the AAMC? You know, is supply keeping up with demand? And do you see the anti- DEI agenda from this administration having any effect on who's going into medicine?

Murchinson:

<Laugh> Well, it is interesting to see numbers skyrocket. And I actually looked up the number of medical schools that have opened in the last five years, and there's something like eight or nine new schools that have already graduated a first class, and, like, another eight or nine schools behind that that are either just opened or getting ready to open. So there's a lot more capacity coming. And today's point, like... Anyone maybe not as close to the baseball field as we are would think that, you know, growth is expanding, but not quickly enough for the projected demand. But obviously, I agree with Dave that that demand is gonna shift. The problem, I think, really, is ... I don't wanna say it's the anti- DEI, but it's, it's the who is being selected from medical school. And, you know, causality is always a little bit debatable, but it looks like the anti-DEI policy is already being blamed for a dip in underrepresented minors and low socioeconomic status representation, and this is at a time when, you know, enrollment's hitting an all- time high. So, you know, we're seeing more Asian and female students. So it's not like no one wants to go into medicine, but it, you know, we're not seeing the diversity we used to see. There's gonna be more homogeneity, like less racial and ethnic diversity,

and, you know, unless schools find some other way to counterbalance these effects without calling it DEI, like looking at income or first-generation status, or, you know, literally just geography, where they're coming from, we're not gonna get there, and we're also not gonna ... You know, it's ... The graduates are becoming more socioeconomically elite. So that piece concerns me because that makes the shortage more acute as more and more of our population is Medicaid heavy, rural, safety net. And, I haven't seen the, necessarily the data on this, but I do believe that, you know, we see a lot of graduates that are more diverse and from, just geographies or income classes where they take advantage of medical school programs to stay in the area for a while; they won't be in the numbers that we might need them to be in the places where we need them to be to deliver care. So it's gonna force a use of some other kind of mechanism, like, oh, technology to get there. <Laugh> Now, it's interesting from, like, if I'm like, in a place where I'm making strategic investments or certainly for, you know, capital, where you need to look at care model innovation. Like, there's just no way around it anymore, and you definitely need to look at retention and productivity tools. Like, there's ... We need to make people more productive, and I think AI is gonna do that. And to me, like, all of it, frankly, points to technology, whether it's consumer facing, workflow enabling, diagnostic, every bit of innovation adoption is gonna matter.

Burda:

Yeah. It's more of a distribution problem, right? Than it is anything else. So, great points. Thanks, Julie. Dave, any questions for Julie?

Johnson:

I'm still sort of struck by what are we doing to people in medical school. And we still largely ... It's not universal anymore, but it's still largely, the selection process for determining who attends medical school is based on the ability of perspective medical students to memorize an absurd amount of information about the human body and the injuries and

diseases that afflict it. So even on The Pit, which, you know, you and I are addicted to, with teaching hospital or teaching ER, we constantly see new doctors tested on their on- the-spot diagnostic and treatment knowledge with answers, usually delivered with a computer-like almost robotic efficiency. And sort of back to your point on tech is given all the tech available to doctors, is this the best way to select and train them? And if you could prioritize the differentiating traits for successful medical school applicants who go on to become doctors, what would those traits be? Would they be the ones we use now, or would it be something else? <Laugh>

Murchinson:

I don't know if you saw Michael Pollen's new book that AI can think, but it doesn't have consciousness. And I think a lot about that in medicine now. Like, the more medicine becomes technological, the more important <affirmative> the human traits are. So what do machines struggle with? They struggle with, they can't build trust. They can't use judgment the way that we think about using judgment. They can't quite deal with ambiguity well, and they definitely don't connect with humans in quite the same way, even though I think that probably will change, to be honest with you. <affirmative> It's changing already, right? So, I mean, honestly, in our, in our day and age, if we could just turn our attention as clinicians to building trust, build trust with patients from different backgrounds, just to get to my comments, explain complexity in, you know, simple language that doesn't require jargon, really focus on health disparities and cultural context and thinking more about the impact of social determinants and not jumping to, you know, more clinically specific answers. And I think we're gonna see a lot of bias in these AI models, as we've been talking about. So we're gonna have to have clinicians really think about what bias could be presenting itself and how to deal with that.

Burda:

You know, it is true that on The Pit, virtually every situation that has a positive outcome, it's always a leap of faith by an individual or trust in their instinct, not a statistic, right? It leads to that positive outcome. And, so I think you're right about, you know, what skills do we need for the physicians in the future. I just hope a lot of these new doctors choose infectious disease as a subspecialty <laugh>, you know? <Laugh> We're gonna need them sooner rather than later, so, I'm afraid. Now let's talk about other big news that happened this past week. Julie, what else happened that we should know about?

Murchinson:

A couple of people on the move this week. First, I heard Jessie Beagle, who was, led innovation at LifePoint and is incredibly talented, has landed herself at OpenAI. So be on the lookout for her. She's gonna do big, big things.

Burda:

Injecting some healthcare expertise there. That's great.

Murchinson:

Hopefully, yeah. And then I'm sure everyone saw Cigna that Cordani is gonna finally call out quits this summer and Brian Ibanko is filling his shoes.

Burda:

<Laugh> Yeah. Yeah. Everybody wants to spend more time with their family when they get in trouble. Why is that? <Laugh> Right? That's great. Dave, what's your big healthcare news of the week?

Johnson:

Well, I mentioned it last week, but it's still kinda gnawing at me, which is Jay Badacharia becoming the acting director of the CDC. And he issued a really quite powerful letter to the staff at CDC about the need to

restore the public's trust in the nation's public health infrastructure. And he, as part of that, identified several core principles. I'm gonna read the first one; scientific integrity and humility. We will follow the evidence wherever it leads, communicate clearly about what we know and what we do not know, and update guidance transparently as new data emerge. And here's what's bugging me, right? You know, credit where credit's due, Badacharia was the one that advised DeSantis on not shutting down the schools in Florida, and that turned out to be a right decision. We, we probably went too far and damaged a generation of kids by putting them in basically homeschooled environments for over a year. So credit there, but he was also, along with Johnny Aynitas very early on in the pandemic, part of that, he led that Santa Clara study that was riddled with methodological errors and it dramatically overstated the presence of the COVID virus and therefore dramatically understated its virulence. And he and Iyanides, rather than acknowledging their errors kind of doubled down. And they were part of the reason that we ended up turning COVID into a political battle almost from the get-go. I mean, if we could, as a nation, couldn't rally around fighting a pandemic caused by a virus, you know, what the hell can we unite around? And so I respect Badacharia, but I hope he takes his own advice to heart. I'd like to see a little bit more humility out of that guy.

Burda:

Yeah, it does go a long way, right? Dave. Thanks. And thank you, Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. You also can subscribe to the Roundup on Spotify, Apple Podcasts, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.