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Recruiting Infectious Disease Physicians: A Deepening Crisis and a Path Forward

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Abstract: The infectious disease (ID) physician workforce faces a recruitment crisis of growing severity. A persistent compensation gap, escalating medical student debt, limited pre-fellowship exposure, and the psychological toll of pandemic-era burnout have together suppressed applicant interest in a field where demand continues to outpace supply. Closing this gap requires deliberate recruitment strategies that leverage the distinct advantages of the private practice model.

Keywords: recruitment; infectious disease; medical education debt

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Highlights

- The fill rate for adult infectious disease fellowship positions has fallen from over 87% in 2019 to less than 50% in 2025, the lowest on record.
- Compensation disparity, medical education debt burden, and limited early exposure are the primary drivers of declining fellowship interest.
- Private practices can compete effectively through transparent compensation structures, flexible scheduling, income diversification, and structured continuing medical education.
- Larger private practices offer meaningful work–life balance advantages, including reduced individual call burden, built-in coverage during emergencies, and structured peer mentorship that rivals academic training environments.
- Proactive, physician-led recruitment is among the most effective strategies for converting fellowship interest into hires.

1. Introduction

Infectious disease physicians occupy a uniquely indispensable role in modern healthcare. They manage complex, life-threatening infections; lead antimicrobial stewardship programs; anchor hospital epidemiology and infection prevention; and serve as the specialty most called upon during public health emergencies. Yet the pipeline feeding this workforce is narrowing at precisely the moment at which the demand for ID expertise is accelerating. Despite a brief pandemic-era surge, applicant numbers have fallen sharply while accredited fellowship positions have expanded, driving fill rates below 50% in 2025 (Table 1) [1–4].

The 2024 cycle illustrates the pace of decline: only 303 of 450 available adult ID positions were filled, the steepest single-year decline on record, with post-match scramble efforts now being a routine necessity for programs attempting to fill residual vacancies [1,5].

Table 1: Adult infectious disease fellowship match fill rates, selected years.

Match Year	Positions Offered	Positions Filled	Fill Rate (%)	Programs Filled (%)
2019	~370	~325	~87.7	~77
2021	404 applicants	~340	~81	~70
2022	~420	~330	~74.4	~63
2023	441	328	73%	~55
2024	450	303	67.3%	51%
2025	>450	<272	<50%	<50%

Sources: NRMP Medicine and Pediatric Specialties Match; IDSA/PIDS match statements; and Arias and Pirofski, *J Infect Dis* 2024.

2. Why Residents Are Not Choosing Infectious Disease

2.1. Compensation Disparities

Infectious disease consistently ranks among the lowest-compensated physician specialties in the United States. The 2025 Medscape Physician Compensation Report placed the ID physician average annual compensation at $277,000, below the $376,000 overall physician average and far below procedural subspecialties such as orthopedics or cardiology [6].

The compensation dissatisfaction among practicing ID physicians is striking: only 34% report feeling fairly compensated, the lowest satisfaction rate of all 29 specialties surveyed in one national analysis, and lower than endocrinology and nephrology, which face similar structural challenges [7,8].

For residents carrying medical school debt and facing a two-year fellowship that delays full attending compensation, this wage gap is not an abstraction; it is a financial deterrent experienced viscerally during career decision-making. A recent cross-sectional survey of internal medicine resident physicians across the United States determined the most reported reason for disinterest in ID was low pay (65.7%) [9]. Notably, compensation outcomes vary significantly by practice model: an internal audit of one large private ID group found that employed physicians earned 18% above the national ID average and partners earned 235% above it, driven primarily by revenue diversification and the strategic use of advanced practice providers (APPs) [10].

2.2. Administrative Burden

ID physicians report spending an average of 19.8 h per week on paperwork and administrative tasks, the highest of any specialty and nearly double the administrative burden reported by anesthesiologists. This disproportionate burden, driven by the consultative nature of ID practice and the documentation

requirements of antimicrobial stewardship and infection prevention roles, is frequently cited by physicians as a source of professional dissatisfaction and burnout [7].

2.3. Limited Early Exposure

Fewer than 10% of U.S. medical schools have an active ID-focused student interest group, and the quality of ID rotations during internal medicine residency varies enormously, leaving many trainees with a limited or distorted picture of what the specialty involves day to day [11,12].

2.4. The Post-Pandemic Paradox

The COVID-19 pandemic produced a brief surge in ID fellowship applications, the so-called 'Fauci effect,' as the public visibility of ID specialists inspired a cohort of residents to pursue the field. But the pandemic also exposed a harsh reality: ID specialists were asked to shoulder enormous institutional, clinical, and public health responsibilities while their compensation failed to keep pace with those demands. For many residents who witnessed this dynamic, the lesson learned was not inspiration but caution [13].

3. Why Recruitment Is a Strategic Imperative

The AAMC projects a national physician shortfall of 86,000 physicians by 2036, driven by population growth, an aging demographic, and a concurrent wave of physician retirements: nearly 20% of currently active physicians are aged 65 or older. ID is particularly vulnerable to these trends given its already strained workforce and the low fill rates that have persistently failed to meet training capacity [14,15].

The consequences of an inadequate ID workforce extend well beyond individual patient encounters. Hospitals without ID coverage face worsening antibiotic resistance rates, higher rates of healthcare-associated infections, and reduced capacity to respond to emerging infectious threats. Communities without access to ID physicians are less equipped to manage HIV, tuberculosis, endemic fungal infections, sexually transmitted infections, and complex cases requiring subspecialty guidance. The burden falls disproportionately on rural communities, underserved populations, and patients with limited ability to travel to urban referral centers [16].

For private practices, the recruitment challenge is direct and immediate: unfilled positions translate to lost clinical capacity, higher call burdens for existing physicians, delayed patient access, and lost antimicrobial stewardship or hospital epidemiology contracts.

4. Strategies for Private Practices to Attract ID Fellows

Private practices occupy a distinct position in the ID recruitment landscape. They can offer a diversified compensation model with graduated income potential, greater scheduling autonomy and peer support. These attributes can be powerful differentiators if marketed effectively and structured deliberately.

4.1. Compensation Transparency and Market-Competitive Offers

Because compensation is the single most consistently cited deterrent to ID fellowship pursuit, private practices must approach compensation offers with both honesty and competitiveness. The IDSA's Physician Compensation Initiative recommends that practices benchmark offers against current IDSA, MGMA, and Sullivan Cotter survey data, and that offer letters clearly enumerate all revenue streams,

including any medical directorship income for antimicrobial stewardship or infection prevention, call compensation, and productivity bonuses [17].

Guaranteed base salaries with transparent productivity ramp-up structures are particularly attractive to fellows navigating early career uncertainty. Practices that tie compensation clearly to measurable outputs including clinical production allow fellows to visualize a direct pathway to above-average ID compensation, countering the perception that the specialty is inevitably low-paying.

4.2. Scheduling Flexibility and Work–Life Integration

Administrative burden is a persistent deterrent in ID, and practices that demonstrate thoughtful management of this burden will distinguish themselves in recruitment. Structured arrangements, including defined call schedules with clear weekend coverage rotations and the use of APPs, signal an organizational culture that respects physician time.

Flexible scheduling arrangements, including options for telehealth-based follow-up and hybrid work structures for outpatient infectious disease care, are increasingly valued by physicians entering the workforce and can meaningfully differentiate a private practice offer. The strategic deployment of APPs further amplifies this advantage: by supporting inpatient workflow and outpatient infusion management, extenders allow physicians to maintain clinical output while reducing the documentation burden and creating time for professional development or personal priorities [10].

4.3. Income Diversification: IV Infusions, Professional Fees, and Telemedicine

One of the most underutilized levers in private practice ID recruitment is the demonstration of income diversification beyond traditional consult-based professional fees. Unlike academic positions constrained by institutional billing structures, private practices have the flexibility to develop ancillary revenue streams that meaningfully augment physician compensation and reduce dependence on any single payer or service line.

Intravenous infusion services represent a particularly compelling opportunity. Many ID conditions require prolonged IV therapy that can be administered in an office-based infusion suite. Practices that establish in-house infusion programs generate per-infusion technical and professional fee revenue. A multicenter study of ID-supervised OPAT across 19 private practice offices demonstrated a 94% success rate and a hospitalization rate of only 2.6% after program enrollment, with comparable outcomes for patients initiated directly from the outpatient setting [18–20]. ID-physician-led OPAT programs are associated with a decrease in OPAT-related readmissions and associated with clinical cure [21].

Professional fee optimization is another lever frequently left unexamined. ID physicians performing antibiotic stewardship medical directorships, infection prevention consulting, or occupational health oversight can bill for these services as medical directorships or consulting arrangements, generating income independent of patient visit volume. Two recently introduced CMS add-on codes offer additional opportunities: G0545, an inpatient add-on exclusive to ID specialists appended to standard hospital E/M codes, and G2211, an outpatient add-on recognizing longitudinal care complexity applicable to office visits. Practices should engage a billing specialist with ID coding expertise to ensure these codes are captured systematically [17,22].

Telemedicine has emerged as a structurally advantageous service modality for ID practices. The consultative nature of much ID work, such as follow-up of known infections, medication management, OPAT surveillance, and HIV care, is well-suited to video-based encounters. Telehealth visit volumes have remained elevated post-pandemic across all specialties, and CMS has continued to reimburse telehealth ID visits at rates comparable to in-person encounters for many services. For fellows evaluating private practice offers, the inclusion of a telemedicine program signals both organizational modernity and a practical mechanism for geographic reach, allowing the practice to serve patients across a broader catchment area without proportional increases in overhead. Practices

with established telemedicine infrastructure can present this to recruiting fellows as a concrete compensation-enhancement pathway.

4.4. Continuing Medical Education and the Conference Commitment

A frequently underappreciated concern among fellows considering private practice is the fear of intellectual isolation, that leaving an academic environment means leaving behind the structured educational culture of fellowship. Private practices can directly counter this perception by demonstrating a genuine commitment to ongoing physician education.

Established practices should offer, and be able to document, a regular schedule of internal educational conferences covering topics such as unusual case presentations, updated treatment guidelines, antimicrobial stewardship data, and emerging infectious disease threats. These conferences, modeled on the grand rounds and case conferences familiar from fellowship training, serve as both professional development and a mechanism for maintaining the intellectual engagement that drew many ID physicians to the specialty in the first place.

Practices may also budget for and actively support attendance at national and regional CME conferences, including IDWeek, the HIV Medicine Association annual meeting, and SHEA (Society for Healthcare Epidemiology of America), in addition to offering financial support for board certification maintenance and relevant online CME subscriptions. Practices that can demonstrate CME support as a formal line item in physician benefit packages signal institutional investment in physician development, a differentiator that resonates particularly with fellows who have spent two years in an intensely educational environment and are reluctant to leave it behind entirely.

4.5. Advantages of Larger Practices

Larger private practices possess structural advantages over solo or two-physician groups that are highly relevant to recruits weighing work–life balance against career satisfaction. These advantages, often taken for granted within established practices, should be articulated explicitly and early in the recruitment conversation. Table 2 summarizes the four principal advantages and the corresponding recruitment talking points for each.

Table 2: Structural advantages of larger ID private practices: recruitment talking points.

Advantage	Description	Recruitment Talking Point
Reduced Call Burden	In a larger ID group, call frequency drops substantially compared to solo or two-physician practices. Weekend, holiday, and after-hours responsibilities are distributed across more physicians, reducing fatigue and improving long-term sustainability.	Present the call schedule transparently during recruitment, including weekend and holiday rotation frequency and any APP or hospitalist triage support.
Emergency Coverage Flexibility	Unplanned absences for illness or family obligations can be redistributed across colleagues in a larger group without creating unsustainable gaps in coverage—mirroring the built-in redundancy of academic departments.	Describe how the group handles unexpected absences. Highlight that no single physician carries an undue burden when a colleague is ill or away.

Table 2: *Cont.*

Advantage	Description	Recruitment Talking Point
Peer Mentorship	New physicians benefit immediately from senior partners' accumulated experience via informal curbside consultations, case discussions, and guidance on the administrative dimensions of private practice—replicating collegial benefits of academic ID in a community setting.	Invite candidates to attend an internal case conference during their recruitment visit. Describe the culture of peer consultation explicitly.
Ancillary Professional Resources	Larger practices can sustain dedicated credentialing staff, in-house ID-trained pharmacists, immigration attorney access for IMG physicians, and malpractice counsel—resources that allow physicians to focus on clinical work rather than administrative overhead.	Signal to recruiting fellows that the practice has invested in infrastructure that lets physicians focus on medicine. Mention pharmacist stewardship support and credentialing staff specifically.

4.6. Active Recruitment: Career Fairs, Networking, and the Physician-Led Approach

4.6.1. The Physician as the Recruitment Point of Contact

In a competitive recruitment environment where fellows are fielding multiple inquiries simultaneously, the single most important structural decision a private practice can make is to designate a physician, not an administrator or human resources coordinator, as the primary point of contact for all recruitment activities. Fellows respond to physicians. When an initial outreach email arrives from a practicing ID physician who understands the demands of fellowship training and can speak authentically about the day-to-day reality of private practice, it carries a weight that no recruiter communication can replicate. This physician recruitment champion need not be the most senior partner; a physician who completed their fellowship relatively recently is often especially effective, given their proximity to the applicant's current experience and their capacity to speak directly to the fellowship-to-practice transition.

The physician recruitment lead should be empowered to initiate and maintain direct, personal contact with candidates from first outreach through final offer, serving as the consistent human connection across what can otherwise feel like an impersonal process. This includes drafting individualized initial outreach emails, following up after conference encounters, answering clinical questions that only a practicing ID physician can credibly address, and acting as the primary voice during the interview day. Research on physician recruitment consistently demonstrates that candidates place the greatest weight on peer relationships and cultural fit when evaluating opportunities; the physician lead is the practice's most authentic ambassador for both.

4.6.2. IDWeek and Specialty Career Fairs

Active presence at specialty career fairs, most critically the recruitment and career development programming at IDWeek, the annual joint scientific meeting of the Infectious Diseases Society of America, is among the highest-yield recruitment investments a private practice can make. IDWeek convenes the full spectrum of the ID community, including program directors, fellows in their final year of training, early-career physicians, and established practitioners. The career fair held annually

at IDWeek provides a structured environment in which practices can present their opportunity directly to motivated fellows who are actively evaluating their next steps. Practices that attend IDWeek consistently, year over year, build name recognition within the specialty community that pays compounding dividends: a fellow who meets a practice's physician representatives at IDWeek during their first fellowship year and again during their second is far more likely to apply when a position opens than one encountering the practice for the first time through a job board listing [5].

4.6.3. Networking with Fellowship Program Directors

Networking with fellowship program directors is an equally essential and often underutilized strategy. Program directors have unparalleled insight into which of their fellows are considering community or private practice careers, which are geographically flexible, and which have specific clinical interests that may align with a given practice's niche. These relationships must be cultivated deliberately and continuously, not merely activated when a vacancy opens. Outreach to program directors should be proactive and personal: a brief, direct email from the practice's physician recruitment lead introducing the group, describing its clinical scope and culture, and expressing genuine interest in connecting with fellows exploring private practice careers is far more effective than a generic job posting. Where geography permits, in-person visits to fellowship programs, offering to participate in case conferences, give a grand rounds presentation, or host a practice site visit for interested fellows, build relationships that translate directly into referrals and applicants [5].

4.6.4. Applicant Communication: Before and After the Interview

Maintaining open, warm, and responsive communication with applicants before and after the interview is not a professional courtesy; it is a core recruitment strategy. In an era when fellows simultaneously evaluate academic faculty positions, hospital employment models, and competing private practices, the responsiveness and tone of a practice's communications send a powerful signal about organizational culture. Before the interview, the physician recruitment lead should reach out personally to confirm logistics, answer preliminary questions, and express genuine enthusiasm for the upcoming visit. Applicants who feel genuinely wanted rather than processed arrive at interview days more engaged and more favorably disposed toward the practice. After the interview, substantive follow-up within 24 to 48 h is critical: a personal note from the physician lead referencing specific conversations from the day signals that the applicant was seen as an individual. Practices that leave applicants in prolonged silence after an interview risk losing them to organizations that respond with greater urgency and warmth.

4.6.5. Designing the Interview Day

The structure of the interview day itself is one of the most consequential elements of the entire recruitment process, and one that private practices frequently underinvest in. An effective physician interview day is not a series of transactional meetings; it is a carefully designed experience that gives the applicant an authentic, multidimensional view of the practice while simultaneously allowing the group to evaluate fit across clinical, interpersonal, and cultural dimensions. The day should be built around meaningful encounters with a breadth of physicians representing different career stages and practice perspectives.

Specifically, the interview day should include time with physicians at multiple points in their careers: a recently hired physician who can speak directly to the fellowship-to-practice transition and the early experience of joining the group; a mid-career physician who can describe how the practice has supported their professional development and clinical interests; and a senior physician who can articulate the long-term trajectory of the group, its values, and its vision. This career-stage diversity serves a dual purpose. It gives the applicant a realistic picture of what joining the practice looks like

in year one, year five, and beyond, and it demonstrates, implicitly, that the practice retains physicians at every career stage, one of the most compelling signals of organizational culture and stability that a candidate can observe during a site visit.

Intentional representation of physicians across genders on the interview panel is not merely a matter of equity; it is a sound recruitment strategy. Research consistently demonstrates that candidates, particularly women physicians, place significant weight on gender diversity within a specialty and practice environment when making career decisions, and that the visible presence of women physicians in a group signals an inclusive culture that meaningfully influences recruitment outcomes. Female applicants who have the opportunity during the interview day to speak candidly with women physicians about work-life integration, scheduling flexibility, and professional advancement in private practice are more likely to view the position favorably. A practice that presents a physician panel reflecting the full gender diversity of the contemporary ID workforce communicates, without a word of policy language, that it is an environment where all physicians can build a career [23].

Perhaps the most underappreciated element of a successful interview day is the deliberate inclusion of a relaxed, social component: a shared lunch, a group dinner, or a casual post-tour gathering, designed to let the practice's physicians show who they are as people, not only as clinicians. Medicine demands that colleagues spend enormous amounts of time together under high-stakes conditions, and prospective hires are not only evaluating the clinical opportunity; they are evaluating whether they will genuinely enjoy coming to work. A meal in a comfortable, informal setting gives physicians the opportunity to reveal their personalities: to discuss interests outside medicine, to share stories that illuminate the practice's culture and camaraderie, and to demonstrate the kind of collegial warmth that no benefits package or compensation structure can substitute for. Applicants who leave an interview day having laughed with future colleagues, and having experienced the social fabric of the group firsthand, carry a fundamentally different and more favorable impression than those who only experienced a sequence of formal office meetings.

5. Conclusion

The infectious disease physician workforce stands at a critical inflection point. Fellowship fill rates have reached historic lows, geographic access is worsening, and the structural conditions that drive this decline, compensation disparities, administrative burden, and inadequate early exposure, have not improved. Yet private practices are better positioned than they may recognize to reverse this trajectory at the local level.

Practices that offer transparent, competitive compensation with clearly enumerated revenue streams, including infusion services, telemedicine, and a fair bonus structure, directly counter the financial deterrents that keep talented residents from pursuing the specialty. Those that invest in continuing medical education, maintain a culture of peer mentorship, and distribute call burden equitably offer something increasingly rare in medicine: a sustainable career with intellectual depth. And practices that invest in physician-led recruitment, building relationships with program directors, appearing at IDWeek and specialty career fairs, maintaining attentive candidate communication, and designing interview days that showcase their culture and team, build the connections that produce hires (Table 3).

The specialty's long-term strength depends on the decisions that private practices make now, not only about whom to recruit, but about what kind of practice environment they are willing to build. Fellows are watching, and they will choose accordingly.

Table 3: Private practice recruitment strategies for ID physicians: summary.

Strategy	Key Actions	Competitive Advantage
Competitive Compensation	Benchmark using IDSA/MGMA data; itemize all revenue streams including bonus structure	Addresses the #1 deterrent directly
Scheduling Flexibility	Structured call coverage; telehealth for follow-up; APP support for consult triage	Addresses administrative burden concerns
Active Physician-Led Recruitment	Physician-led outreach; IDWeek career fair attendance; program director networking by email and in person; elective rotations; personalized pre- and post-interview communication; structured interview day with multi-career-stage panel and social component	Builds pipeline before positions open; differentiates practice culture through authentic physician-to-physician engagement
Income Diversification	Establish in-house IV infusion suite for OPAT and complex infections; optimize ASP/IP medical directorship billing; develop telemedicine program for follow-up and HIV care	Augments compensation beyond consult fees; reduces payer concentration risk
CME Commitment	Weekly internal conferences; budget for national conference attendance; CME subscription support; board certification maintenance funding	Counters fear of intellectual isolation; preserves fellowship-era educational culture
Work–Life Balance and Mentorship	Present call frequency transparently; highlight emergency coverage flexibility; describe peer mentorship culture; invite candidates to attend internal conferences during recruitment visits	Structural advantage of group practice; replicates academic collegial benefits in community setting

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