The Impending Physician Shortage

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Darrell G. Kirch, MD, CEO of the Association of American Medical Colleges, Washington, D.C., has defined physician shortages in the United States as not simply an economic issue but a moral issue. It is a continuing source of surprise that the United States should continue to experience physician shortages given its reputation as an educational magnet to the world. An AAMC report, *The Complexities of Physician Supply and Demand From 2016 to 2030: 2018 Update*, shows 51,680 individuals applied to U.S. medical schools, with 22,388 matriculating—41 percent gaining admission.

Perhaps these figures would not seem troubling were there neither a deficit in the number of practicing physicians, nor one projected in the future. The AAMC 2018 projection suggests that in 2030 the U.S. will experience a physician deficit, ranging from 43,000 to 121,000 physicians at the peak of the baby boom retirement. Contributing factors include increased patient demand and diminished physician supply resulting from the retirement of current practitioners. This shortage will be more acute, it is argued, in the less lucrative primary care disciplines.

This report has been controversial, with critics arguing that the problem is the poor use of physician time on nonclinical tasks and changing work hours expectations of younger physicians.

Geographic and specialty maldistribution also are suggested as root causes. Ezekiel J. Emanuel, MD, PhD, vice provost for Global Initiatives, the Diane v.S. Levy and Robert M. Levy University Professor, and chairman of the Department of Medical Ethics and Health Policy at the University of Pennsylvania, has been a vocal critic of the more dire projections of a shortage that is already in the making.

PHYSICIANS TRAINED ABROAD AS A FORM OF SOLUTION

However one views the current and future availability of physicians, there is no question that the reliance on physicians educated outside the United States has prevented the situation from becoming more alarming. The U.S. Department of Health and Human Services reported in 2016 that approximately one quarter of all active practicing physicians in the U.S. received their medical degrees from nations other than the U.S. or Canada.

Aaron Carrol, MD, professor of pediatrics at Indiana University School of Medicine, noted in a November 2016 article in *The New York Times* that the U.S. has fewer practicing physicians per 1,000 people than 23 of the 28 Organization for Economic Cooperation and Development industrialized nations. The U.S. ranking for primary care physicians is only slightly higher at 24 of 28 OECD nations.

International medical graduates have been viewed as a vital, albeit partial, solution to access and distribution issues as they are more likely to practice primary care than to specialize. In addition, their willingness to practice in rural and urban locations that are underserved by other physicians is a distinct contribution to the U.S. system. Recent political focus on the revision of immigration laws in the United States has refocused attention on this issue, as highly skilled workers are viewed as desirable from an immigration perspective.

PROBLEMS FOR NATIONS OF ORIGIN

Professional migration of highly educated individuals from developing to developed countries helps increase the supply of a skilled workforce in high-income countries, but it is viewed as a serious constraint on the development of poor countries.

This can be especially troubling in the realm of healthcare. Paul Edward Farmer, MD, PhD, Kolokotrones University Professor of Global Health and Social Medicine, Harvard Medical School, has argued that a population's poor health impedes economic growth. The focus of concern is on impoverished nations, particularly those in sub-Saharan Africa. Fifty nations in the world have no medical school at all and are in the vulnerable position of importing physicians out of necessity.

The impact of physician out-migration on source countries is mixed. The clearly negative consequence is an increased shortage of physicians resulting in fewer available health services. The transfer of these skills from the source country might be viewed as a subsidy of sorts to the wealthier country and a reversal of usual economics.

There also are some benefits to the source country. Remittances back to the families or governments of these nations confer direct economic benefit. In the unusual case in which a physician returns to his or her country of origin, significant skills and experience will be gained. China, India and the Philippines have used the export of physicians as an economic strategy, and the United Kingdom has recognized this by exempting these nations from controls to discourage emigration to the U.K. from vulnerable countries.

THE WORLD HEALTH ORGANIZATION POLICY STATEMENT

Julio Frenk, MD, president of the University of Miami, identified the gaps and inequities in health between and within countries in a 2010 article in *The Lancet*. He pointed to new infectious, environmental

and behavioral threats superimposed on rapid demographic and epidemiological transitions. He also noted common themes across all societies, notably a significant increase in chronic conditions and patients becoming more proactive in health-seeking behavior.

In response to these considerations, the World Health Organization in 2010 adopted a Code of Conduct on the International Recruitment of Health Personnel. This voluntary policy statement asks member nations to refrain from active recruitment of health professionals from countries with personnel shortages.

THE AUTONOMY OF PHYSICIANS IN A GLOBAL LABOR MARKET

Physicians seek training in the U.S. and other developed countries for learning opportunities that are unavailable to them in their home nations. This may be due to limited availability of capable faculty to instruct, or from a lack of technologies readily available in more affluent nations. In the course of training, economic opportunities may present themselves that are better than in the physician's country of origin. A classic component of the concept of physician autonomy has been the right of the physician to determine locus of practice and specialty based on training. Should this choice be limited in the case of internationally trained physicians?

GUIDANCE FROM ACHE'S *CODE OF ETHICS*

ACHE's *Code of Ethics* stipulates that the healthcare executive shall "Work to support access to healthcare services for all people." As executives, our assessment of our community is routinely defined as a geographic entity, and healthcare is famously seen as local in nature. To satisfy the challenge of the *Code*, "to participate in public dialogue on healthcare issues . . . ," one must adopt a broader perspective on the problem of physician migration that transcends local and national boundaries.

In the present, an ethical executive will hire or encourage the hiring on merit of the most competent physician available for the benefit of patients served, without consideration of his or her nation of origin within the context of immigration laws. However, the long-term problem of a U.S. physician shortage requires policy solutions that will allow the United States to achieve self-sufficiency in ensuring adequate physician supply for its health needs. This could be addressed in a variety of ways, including physician extenders, technological advances and improved organization of care.

Policy goals that executives might consider include advocacy for expanded medical school opportunities for both allopathic and osteopathic physicians. Health systems such as Geisinger, Danville, Pennsylvania; Kaiser Permanente, Oakland, California; and Carilion Clinic, Roanoke, Virginia, have already moved in this direction by establishing medical schools. This might eventually allow the training of medical students in the U.S. to return to their nations of origin.

The U.S. educates a significant number of foreign students in engineering and science but not in medicine. Revising caps on residency funding through Medicare established in the Balanced Budget Act of 1997 would further relieve the shortfall of residency opportunities for U.S. medical graduates. Only through these broader policy initiatives can an ethical resolution to professional migration be attained.

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Discussion Questions

A number of high-income countries have built hospitals and sent physicians to low- and middle-income countries to help train the trainers in an effort to reduce the volume of physicians immigrating to the United States. However, given our

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country's dependency on foreign-trained clinicians, these worthy efforts exacerbate our physician shortage problem. Other than building more medical schools in the United States, revising the caps on residency funding, and increasing the capacity of existing schools, what other ethically acceptable options might be considered?

Given that most healthcare executives may already feel overextended, offer some thoughts about when and how this dilemma can be addressed.