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Beware of Medical Quick Fixes

The geographical maldistribution of physicians in the United States has proved a remarkably stubborn problem. Physician to population ratio has risen from 142 per 100,000 in 1960 to 250 per 100,000 today *(1)*, yet physician recruitment and retention in rural and inner city areas remains a major problem. The National Health Service Corps currently lists 2,841 Health Professions Shortage Areas that would require 5,495 primary care physicians to achieve a minimal level of staffing and 12,720 to reach the national average for coverage—numbers virtually unchanged since the early 1980s despite a steadily growing national pool of physicians *(2)*.

Local physician shortages combined with large numbers of international medical graduates (IMGs) interested in establishing practices in the United States, have led many underserved areas to recruit IMGs. Despite efforts to attract IMGs, the data show that the ultimate practice patterns of IMGs in terms of location and specialty are very similar to their U.S.-trained counterparts *(3)*. This suggests that although some IMGs may begin their practices in underserved areas, they subsequently gravitate to more lucrative and more urban areas.

The tradition of foreign trained physicians migrating to the United States has established a deep set of family, cultural, and professional grooves that facilitate the continued arrival of physicians from around the world. To enter practice in the United States, foreign trained physicians must have passed U.S. licensure exams—now the uniform U.S. Medical Licensing Examinations—and have had some amount of U.S. residency training. For residency positions, they must have passed language and cognitive exams given by the Educational Commission for Foreign Medical Graduates. These requirements are substantial, and many physicians arriving in the United States either have not had the preparation or have not had it recently enough to obtain medical licensure. For them, the physician assistant (PA) category suddenly offers the promise of employment.

The problem is, of course, that the PA is not just a dilute doctor. Rigor in training and examination of PAs calls for cognitive and clinical skills and knowledge of contemporary medical practice. Howard and his colleagues dramatize the gap between unlicensed IMGs and recent PA graduates in both medical knowledge and clinical applications. The IMGs fared poorly in all areas.

This important finding replicates similar testing done in New York State in 1993. The history of legislative retrenchment on the quick and easy licensure of IMGs as PAs suggests that States that once embraced a quick fix have had second thoughts based on performance.

Why do State legislatures continue to entertain the clearly naive notion that any physician is a physician and short cuts are fine to create more PAs? The answer seems to lie in the potent nexus between clever and persistent lobbyists for the IMGs and the continued existence of underserved areas that can always be held up as a rationale to put more clinicians into play. The Howard study and the body of experience it summarizes should provide ample evidence that short cutting IMG training requirements to produce PAs will not generate quality health care providers. Local physician shortages can be alleviated by dedicated scholarship and loan repayment programs, practice incentives, and networks of providers where PAs would play a prominent role.

Quick fixes will not do it.

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References

1. Physician Characteristics and Distribution in the U.S., 1984 and 1994 Editions, Department of Data Services, Division of Survey and Data Resources, AMA, 1994
2. Selected Statistics on Health Professions Shortage Areas, June 30, 1995, Division of Shortage Designations, Bureau of Primary Health Care, Health Resources and Services Administration
3. Mullan, F., Politzer, R., and Davis, H.: Medical Migration and the Physician Workforce. JAMA 273:1521–1527 (1995)