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Letters

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Broadening The Scope Of Physician Supply Projections

To the Editor:

I found the study by Steven Jacobsen and Alfred Rimm, “The Projected Physician Surplus Reevaluated” (Health Affairs, Summer 1987), to be most interesting but somewhat limited in scope. That is, the authors pay close attention to the raw number of physicians graduated without any recognition of specialty choice and practice location site selection.

Having been closely associated with the Area Health Education Center (AHEC) program in California, I have had the opportunity to observe firsthand the dynamics of both specialty choice and geographic distribution. While the Graduate Medical Education National Advisory Committee (GMENAC) report did not address specific maldistribution issues, it did forecast significant surpluses of specialty-trained physicians in contrast to those in primary care. That prediction has come true in California where, statewide, the only underrepresented group of physicians is family practitioners.

Coupled with specialty maldistribution is the issue of geographic maldistribution. For example, despite the concentration of physicians in particular geographic areas, such as the San Francisco Bay area, California continues to have a large number of both urban and rural health personnel shortage areas. The assumption that the forces of supply and demand will cause a redistribution of physicians into underserved areas is a fallacy. My experience with AHEC indicated clearly that physicians will establish a practice in an area similar if not identical to the one where they grew up and where they can expect to make a reasonable living. Further, the experience of the National Health Service Corps underlines the difficulty inherent in providing incentives to physicians to practice in underserved communities. I believe that future research should recognize that the current and projected physician oversupply is also strongly influenced by both specialty and geographic maldistribution.

Leonard H. Friedman
Division of Health Related Professions
University of Southern California

Envisioning The Future Health System: A Tribute To Wilbur J. Cohen

To the Editor:

More than fifty years ago, Wilbur J. Cohen began to envision what would become Social Security, Medicare, and Medicaid. These programs have enabled citizens to have not a feather bed but rather a safety net to protect their independence, dignity, and freedom of choice about the services and security these social legislations provide. Through some sixty pieces of legislation, of which he was the principal architect, Cohen’s compassion for people, his respect for learning and hard work, his love for public service, and his concern for social needs came to fruition.

Yet Cohen continued to have a dream that today still has not been realized. He envisioned a universal nationwide health care system that provides the right to both a full range of services and a high quality of health care irrespective of race, sex, age, income, or national origin. Every person would be assured access to those health services that pro-
essional providers believe are necessary for the needs of individuals throughout their lives, regardless of ability to pay. This system would have a well-organized and planned arrangement of primary, secondary, and tertiary health care centers. Convenient access to prenatal, postnatal, and family planning services would assure that every child is born wanted and well.

Financing for this system would be over an individual's life cycle so that small, regular contributions would entitle everyone to acute accident, preventive, catastrophic, and long-term care. Cost would be distributed equitably among individuals, families, businesses, and those with higher incomes. Such a system would evolve out of our experiences, our heritage, our competition, and our compassion. It would take into account cost constraints, efficiency, and effectiveness. It would be humane, compassionate, and would assure dignity and self-respect. It would avoid, even abolish, stigma in the receipt of health care.

The nation's health care delivery system continues to move toward the dream of Cohen and other visionaries. Ever since Roosevelt's social reform of the 1930s, the national health insurance plan remains the one element in the safety net that has not been implemented. Grass-roots support for such an idea did not exist in 1934. Truman failed to implement it as Roosevelt's postwar plan. Kennedy and Johnson moved a step in that direction with the passage of Medicare and Medicaid. Carter tried to implement national health insurance, but failed. Now, Reagan has accepted a small but significant improvement in Medicare that ultimately brings us a step closer to universal health insurance.

Reagan's recommendation in 1987 to broaden Medicare by making hospital insurance cover so-called catastrophic high and prolonged costs is further recognition of the public sector's expanding role in meeting health care costs. This is all the more significant since Reagan was one of Medicare's most vigorous opponents in 1965.

Congress likely will enact some form of catastrophic hospital insurance this year, and it is also possible that some small steps in the direction of long-term care may be included as an amendment. Once such coverage becomes law, the next major step will be to add long-term care insurance coverage. Such coverage will leave room for private-sector supplementation, private management and ownership of nursing homes, and state supervision and regulation of the scope, quality, and reimbursement of services.

In 1987 we began an accelerated crescendo that will culminate in major social reforms in the 1990s. A careful study of American history indicates that whatever these changes will be, their roots are being formed right now. I believe there currently exist the beginnings of a new strategy, and revised priority, even an old scenario in new dress for the 1990s. That strategy will become part of the American way of life through the next decade, just as social reforms enacted earlier in this century have come to be accepted and retained despite all of the critical rhetoric invoked against them. But still there will be new problems, new challenges, and new programs. As we ponder this vision, not only should we remember Wilbur J. Cohen, but, more importantly, we should study the path he has shown and build upon it.

Lonna Milburn
The Lyndon Baines Johnson School of Public Affairs
The University of Texas at Austin

Physician Assistants As Alternatives To Foreign Medical Graduates

To the Editor:

After reading Stephen S. Mick's article, "Contradictory Policies for Foreign Medical Graduates" (Health Affairs, Fall 1987), one is left with the impression that, as a consequence of reductions in the numbers of foreign medical graduates (FMGs) entering graduate medical education, service delivery gaps are likely to occur, particularly in certain types of hospitals (unaffiliated and nonmajor teaching) in certain geographic areas (Middle Atlantic and East North Central states). Regarding the deep cuts projected in FMG resident numbers, Mick says, "substitutes need to be found for FMG residents in hospitals with less than full university affiliation, in smaller cities, and obviously, those with proportion-
ately high complements of FMGs." Several strategies to address the shortfall in service delivery brought about by FMG restrictions are discussed.

Unfortunately, Mick does not mention a strategy that has been considered and adopted by a large number of the specific types of institutions under discussion. That strategy is the incorporation of physician assistants (PAs) as house staff working in a variety of inpatient roles. Since the early 1980s, hospitals have employed PAs to augment inpatient staffing arrangements, often in circumstances where residency programs have been curtailed or eliminated. The use of PAs has permitted directors of residency programs to adjust staffing patterns to balance patient care service requirements with externally imposed or internal educational needs.

The incorporation of PAs into inpatient units, whether or not affiliated with physician residency programs, began as far back as 1972 when the Montefiore Medical Center in the Bronx hired PAs to augment its surgical house staff. Currently, Montefiore employs about eighty PAs working in a wide variety of specialties and inpatient units. Since then, a substantial number of other hospitals have utilized PAs; many of these institutions are precisely the types of hospitals discussed by Mick as ones most likely to be affected by FMG restrictions.

Over one-third of the estimated 18,000 clinically active PAs are practicing in the inpatient hospital setting. Published reports have attested to the success of staffing arrangements where PAs work with junior and senior residents and attending physicians on medical, surgical, and pediatric services. Unlike residents, PAs remain on service for long periods of time, thus increasing continuity of care, maintaining high quality of patient care, and increasing staffing flexibility. In consideration of future health personnel policy directions, it seems important and appropriate to recognize the contribution that PAs make to hospitals, particularly those that were formerly dependent on FMGs.

James Cawley, Associate Professor
The George Washington University Medical Center

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Separating FMG Issues From Physician Supply Issues

To the Editor:

In the Fall 1987 Health Affairs, Stephen S. Mick suggests that current policy debates regarding graduates of foreign medical schools (FMGs) should consider the possibility that any actions that would effectively decrease the number of FMGs entering graduate medical education (GME) programs in this country might ultimately aggravate the current geographic maldistribution of physicians. Although Mick makes a number of valid points, I believe that his conclusions are based upon an inaccurate interpretation of certain facts, and I would challenge the concept that physician supply issues are relevant to FMG-related policy debates.

To begin, if there is now, or shortly will be, an aggregate surplus of physicians in this country, it is simply incorrect to suggest that FMGs have not contributed to the surplus. At present, over 20 percent of the practicing physicians in this country are FMGs. Even though the number of FMGs entering graduate medical education has decreased in recent years, FMGs still fill approximately 18 percent of all GME positions. Thus, the fact that FMGs make up a smaller percentage of physicians entering practice now than during the peak years of the 1970s does not change the fact that FMGs have contributed, and continue to contribute, to any surplus that may
exist. Thus, limiting the number of FMGs entering graduate medical education will decrease the total supply of physicians.

Second, Mick's projections of the impact that limiting FMGs' access to graduate training might have on the current geographic maldistribution of physicians are particularly problematic. The most serious problem is that there is little rationale for projecting future practice patterns of FMGs who entered practice in the 1970s. The relative distribution of U.S. and non-U.S. citizens among FMG cohorts has changed remarkably during the past fifteen years. Probably more important, the forces influencing the decision of any physician to enter solo or group practice, or to settle in a rural or urban area, have changed dramatically during the same period and will undoubtedly continue to change in the future. Thus, there is no reason to believe that an FMG entering practice in the 1990s would make the same kind of choice made by an FMG entering practice in the mid-1970s. There is no way to predict accurately the impact that limiting FMGs might have on the geographic maldistribution of physicians, whether or not there is a physician surplus.

Those points aside, Mick's analysis is rooted in conventional thinking that inexorably links policies governing FMGs to physician supply issues. In my view, this is an unfortunate element of these policy debates. Given the traditions of this country and the contributions that FMGs have made to the country and the profession, we would do well to reframe the policy debates regarding FMGs and physician supply. We should not encourage policy fluctuations that would permit FMGs relatively open access to graduate medical education in this country during periods of perceived physician shortage, and yet limit access during periods of perceived surplus. Our FMG policies should be based upon the principle that all qualified individuals should be treated equally. We should first and foremost ask ourselves whether our policies regarding FMGs are fair, not whether we need FMGs to care for poor or rural Americans or to fill other practice positions considered undesirable by graduates of our domestic medical schools.

Michael E. Whitcomb, Dean
School of Medicine
University of Washington, Seattle

Reducing FMG Numbers Could Have 'Serious Medical Consequences'

To the Editor:

"Contradictory Policies for Foreign Medical Graduates" by Stephen S. Mick (Health Affairs, Fall 1987) presented a clear, empirical examination of issues relating to foreign medical graduates (FMGs). As Mick indicates, large concentrations of FMGs are found in the Middle Atlantic states (New York, New Jersey, Pennsylvania) and in the East North Central region (Michigan, Illinois, Ohio). As of 1985, more than 38 percent of all residents in New York City hospitals were FMGs. The percentage of FMGs in hospitals in the economically depressed and medically underserved areas of the city was, and remains, high. In some cases, FMGs fill over half of residency training slots. Many of these inner-city hospitals have great difficulty attracting graduates of American medical schools, making FMG residents a key source of physicians. Their elimination would leave these communities and hospitals understaffed.

Unlike other parts of the country, hospital occupancy rates in New York currently are rising. A spot check of occupancy rates for not-for-profit voluntary and municipal hospitals conducted by the Greater New York Hospital Association (GNYHA) in October 1987 showed thirty-four of forty-six voluntary hospitals citywide at or above 90 percent occupancy, as were all eleven municipal hospitals. Seventeen of the voluntary hospitals were at or above 100 percent occupancy. Compounding the occupancy problem is the present and predicted future demand for acute care services by patients with acquired immunodeficiency syndrome (AIDS). According to recently released figures presented in a New York State Department of Health draft report, by 1991 New York City will have an average daily inpatient census of over 2,300 patients with AIDS or AIDS-related illnesses. As of October 1987, a GNYHA survey revealed 1,335 patients with con-
firmed and suspected AIDS in New York City hospitals.

Assessing the situation as we know it today, it appears to me that by 1991 New York City must add a minimum of two to three new or refurbished hospital facilities and appropriate professional staff to adequately cope with increased demand for acute care. To exact any dramatic policy change at this time that would interfere with the availability of physicians, such as reducing or phasing out Medicare reimbursement for the costs associated with training FMGs, would have serious medical consequences.

GNYHA firmly believes that only truly qualified FMGs should be permitted to enter training programs here. The pass rate for the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) is just 16 percent, effectively assuring that only qualified FMGs are placed in U.S. residency training programs.

In the final analysis, our goal must be to provide high-quality medical care to all, making physician supply issues paramount. Reduction in the number of alien and U.S. FMGs now would severely threaten our ability to deliver acute critical care to those who need it. As Mick’s article shows, there appears to be no compelling reason to further restrict the entry of FMGs—either alien or U.S.—into U.S. residency programs for the foreseeable future.

Kenneth E. Raske
President, Greater New York Hospital Association

Balancing The FMG Debate

To the Editor:

One purpose of my article, “Contradictory Policies for FMGs” (Health Affairs, Fall 1987), was to provoke discussion about and to act as a counterbalance to a health policy debate about foreign medical graduates (FMGs) that often assumes that reductions of FMGs are automatically a good thing. The responses published in this issue of Health Affairs indicate that this purpose has been partially fulfilled.

Cawley’s point about use of physician assistants as alternatives to FMGs is an excellent one and is something I should have mentioned as a policy option. There are several caveats that anyone espousing this line of reasoning should consider, however. First, without denigrating the type or quality of care delivery by physician assistants, there will always be a question whether that care is equal to that provided by physicians, whether they be FMGs or U.S. medical graduates. Because my analysis examined possible practice patterns of postresident FMGs, not FMG residents, this point is underscored: the comparison should not be to FMG residents but to FMGs who have finished their graduate medical education. Second, growth in the number of physician assistants appears to have slackened in recent years, and it is unclear that there would be enough of them to substitute for postresident FMGs in the early to mid-1990s should FMGs be prohibited to enter into residency training now.

Whitcomb’s view contrasts with mine that FMGs have not contributed in the past ten to fifteen years to the physician “surplus” in the United States. Clearly, FMGs are a substantial proportion of the physician labor pool, but it is still a fact that during the period of the greatest growth in U.S. medical graduates, there was also the greatest decline in the numbers of FMGs. At present, there is a more or less steady input of FMGs (both foreign national and U.S.-citizen) and an actual decline in those who are U.S. citizens. Projections of physician growth by the American Medical Association, the Graduate Medical Education National Advisory Committee (GMENAC), and the Bureau of Health Professions all show a consistent pattern: even with cutbacks in FMGs, the physician pool will continue to grow faster than population growth, absent cutbacks in the number of U.S. medical graduates.

It is true that the projections I made in the article are based on assumptions that may well not hold true, and it was not argued otherwise. That is the nature of projection methodologies. However, one must begin with some baseline projections, and it behooves us all to show where the assumptions are misleading and to make the appropriate adjustments. Hence, my position was, without
changes in the parameters, the situation would be as predicted; the challenge is to specify which parameters will shift, how much, and what impact they will have. By examining the assumptions, one finds clues to what things would have to be changed to have an outcome different from that which is predicted, a point seemingly lost on Whitcomb. His reasoning is that "there is no way to predict accurately the impact that limiting FMGs might have on the geographic maldistribution of physicians." Perhaps it is an issue of semantics and the meaning of "accurate." If so, I suggest that the interested reader pursue a more statistically thorough approach (including confidence intervals of parameter estimates) I have published elsewhere.\(^1\)

Whitcomb's final point has great merit. It would be progress if considerations of physician supply would emphasize fairness, equity, and quality first, and the various "numbers games" second. However, the numbers game is real: medical schools play it when considering class sizes and budgets; specialty societies play it when considering whether there are "too many" physicians in a specialty. In fact, Whitcomb plays it when he uses the phrase "during periods of perceived surplus." His position about all qualified individuals being treated equally is implicitly couched in a logic that numbers are important.

Finally, I doubt that patients of FMGs in underserved areas and populations would understand his rationale that the care provided to them should not be primarily in the minds of policymakers as they consider eliminating FMGs from U.S. medical practice. As has been the case for decades, the trick will continue to be to induce U.S. medical graduates to do what FMGs apparently are more willing to do.

Raske appears to agree with the thrust of my article, particularly as policy changes might negatively affect acute care services in New York City. Officials in the New York State Department of Health recently have proposed a series of radical reforms in graduate medical education, including dramatic reduction of the number of residency slots and a decreased reliance on FMGs.\(^3\) They also have proposed reducing the hours of time that residents are continuously on duty.\(^3\) These recommendations were made with the full knowledge that either U.S. medical graduates or physician assistants will be needed to fill the roles vacated by FMGs. There are those who doubt that sufficient U.S. medical graduates or physician assistants will be available or willing to do this. Hence, there is a lively debate in New York State, and it will be important for observers to watch what the outcomes are since New York may be a bellwether for the nation.

Stephen S. Mick
School of Hygiene and Public Health
The Johns Hopkins University

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4. A. Cellhorn, "Graduate Medical Education in New York State" (paper presented at the Annual Meeting of the American Public Health Association, New Orleans, La., October 1987).
points must be considered for future analysis. Rutkow argues that the number of surgeons has increased sufficiently with a concomitant stabilization in the number of operations to threaten the “critical mass” of surgery necessary (on average) to maintain surgical competence. Although his methodology contains a serious weakness using existing national databases (in that ambulatory surgery, which is not counted, was probably responsible for a significant number of aggregate procedures in 1987 and growing rapidly), his findings suggest what practicing surgeons see all around them: flattering demand for many procedures and a relatively increasing supply of surgeon competitors. This environment is likely to affect the newly trained surgeon most, since surgical workloads are unbalanced in favor of the more established competitor.

Rutkow does raise some reflective issues vis-à-vis surgical workloads and the quality of surgical care. However, the question for the surgical policy analyst should more precisely be: “What degree of both relative and accumulated volume for a given surgical procedure (that is, with a certain surgical case complexity) is necessary to maintain a competent outcome (that is, surgical quality)?” The Rutkow level of two to three major operations a week is not particularly worrisome, but I believe that a growing number of surgeons may be doing less than this number, which may jeopardize competency.

The analysis by the American College of Surgeons appears analytic and raises other questions regarding the aggregate supply of surgeons. Their analysis of numbers of surgical residents suggests that the aggregate output has leveled or decreased slightly; however, the number of surgical residents in the pipeline still seems relatively high.

The Misek/Karnell analysis also alludes to the influx of women into American surgery; it is unclear how the gender change for surgeons may affect aggregate surgical workload on the margin, although analysis of other industries suggests that the workload/surgeon relationship may change. The most distressing data from this report, however, show that the aggregate production of surgeons still remains high (but not growing), and although the final numbers of surgeons produced in America may be less than the original analysis of the Graduate Medical Education National Advisory Committee (as these and other authors contend), it still appears that there will be too many surgeons in the days ahead.

Many surgical health policy questions remain for the future. Databases must be improved to capture aggregate numbers of surgical procedures for both the inpatient and outpatient setting, given that health care financing changes under way are changing the site for surgical care delivery. Analytic study needs to be done regarding the “critical mass” of surgical operations necessary to maintain surgical competence (and what factors influence same), and where regionalization and specialization for certain surgical procedures may offer gains in efficiency and/or outcome.

Eric Munoz
Long Island Jewish Medical Center

Are Relative Value Scales The Answer?

To the Editor:

By using selected 1984 Medicare data in the DataWatch “Are Some Surgical Procedures Overpaid?” (Health Affairs, Summer 1987), Janet Mitchell and her colleagues ask us to accept a series of assumptions and then make leaps of reasoning in their analysis of the import of their data manipulations.

The 1984 Medicare data set has many flaws. In 1984, Medicare insurance carriers were in the process of converting to the first national uniform coding system. Unlike hospitals, physician services had been a local matter, reported and coded differently by every carrier.

Proof of the confusion in the coding system transition appears in the authors’ listing of cataract surgery procedures. Rather than listing the four descriptions of lens extraction commonly used by ophthalmologists, the authors simply list “lens extraction, intracapsular.” This accounts for none of the variations on this procedure that an ophthalmologist might encounter.

During the early 1980s, cataract surgery underwent a series of dramatic changes that the carriers had trouble keeping up with,
including increased acceptance of local anesthesia, use of viscoelastic substances, great improvements in the quality and safety of the intraocular lens (IOL), growing acceptance of the extracapsular technique, and nearly forced exit to the hospital outpatient department. The potential impact of these changes was neither acknowledged nor examined by the authors.

The authors allude to another clue that the 1984 data are flawed: they were forced to conduct their study on the highest-volume procedures because of the great variability of all other procedures. They dismiss this, saying that high-volume procedures are worth study since they represent 17 percent of all operations performed on the elderly.

I would argue that, despite such a high number of claims, the information is likely to be as uneven and misleading as it would be for lower-frequency procedures. Also, these surgeries are in great demand by the Medicare-aged population because they are highly successful, reasonable in market value compared to their outcome, and possibly the best solution to the particular ailment.

These market forces are given short shrift by the authors. They ask the reader to assume that the resource-based relative value scale (RBRVS) is a true snapshot of the actual resources contributing to a particular procedure, but they offer no proof that the researchers' model is practical. Indeed, they briefly admit to a "major conceptual limitation" of the RBRVS: "Resource costs, even if accurately calculated, are incomplete measures of the value of physician services. Expected health benefits to the patient also need to be included in the definition of relative values."

The authors superficially address the issue of containing Medicare costs by adjusting physician payments, saying that to achieve the cost savings associated with implementing their recommended reductions, and yet not shift the costs onto the Medicare patient, two fundamental changes in the program should be made: (1) require physicians to accept Medicare's payment scale as their full fee—mandatory assignment; and (2) establish a "super" preferred provider list of physicians willing to accept assignment. Beneficiaries would receive Part B benefits only if they go to those physicians; but they would have no out-of-pocket expenses.

First, the current assignment rate is relatively low because the Medicare-allowed rate historically falls below the physician's actual charges, especially for office visits. The assignment rate for surgical procedures is much higher because of competitive pressures and the difficulty in otherwise collecting the surgical fee. Therefore, the realistic implementation of any form of RVS likely would not raise office visit fees high enough to encourage the cognitive providers to accept assignment, and would cut the fees so deeply for the surgical providers that the majority who have been accepting assignment voluntarily might stop doing so.

Second, a Medicare preferred provider organization (PPO) is anathema to the purpose of the program: providing equal access to the best physicians and the physicians of choice.

The authors claim that the current payment system is inflationary and creates incentives for overuse of many procedures. However, they do not substantiate either argument. Granted, Medicare probably needs reorganizing, streamlining, and updating, especially in the rapidly changing health milieu. However, this must be done with a commitment to fairness and appropriate reimbursement, not for the sole purpose of meeting an impossible dollar reduction level.

The authors conclude: "Ultimately, society is interested not only in the relative values of medical services but in the relative values, and hence annual incomes, of internists, general surgeons, cardiovascular surgeons, and ophthalmologists." Obviously, when the government has the responsibility to pay for care, it must also be responsible to the taxpayers who foot the bill. Nonetheless, an individual professional's annual personal income is no business of the government's.

If this "ultimate" goal is the driving force behind the development of an RBRVS, then there will be even greater resistance to its implementation than one can see developing now.