WELCOMING A NEW EDITOR

We are delighted to welcome John J. Frey III, MD, as a new associate editor at the *Annals*. Dr Frey joins us at a time when the number of manuscripts received is increasing and when the diversity of topics that make up the field of primary care and health care require broadening our expertise.

Dr Frey is a family physician, educator, and leader. He has experience in medical editing for *Family Medicine* and the *Wisconsin Medical Journal*. He recently completed his second term as a member of the National Library of Medicine Literature Selection Technical Review Committee. Dr Frey brings to his role as editor an international perspective, a strong grounding in the fundamentals of generalist practice, and a sanguine vision of the future.

Please share your insights by joining the *Annals* online discussion at http://www.AnnFamMed.org.

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EDITORIAL

Recruiting Primary Care Physicians From Abroad: Is Poaching From Low-Income Countries Morally Defensible?

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US medical graduates displayed their continuing disdain for family medicine this year, as shown by the results of the 2007 National Resident Match Program. US graduates filled only 42% of the family medicine residency slots available (2,621 total slots), with the rest coming from other countries (1,206) or going unfilled (308).[1]

Barbara Starfield and George Fryer, in this issue of the *Annals*, explore the origins of those thousands of foreign-trained physicians landing on American shores to provide primary care. Indeed, more than 28% of US primary

care doctors have been trained abroad, typically in countries with poor health indicators and shortages of physicians (although in previous generations medical immigrants tended to be from Europe).[2]

Physician migration patterns reflect thousands of individual and family-level choices based on judgments of economic, social, professional, and other interests. Article 13 of the 1948 Universal Declaration of Human Rights asserts that "everyone has the right to leave any country." Social justice and immigration rights advocates endorse that well-established human right. But what if the person leaving his country wants to take with him the assets of others he leaves behind? What if those remaining in the home country experience, as a result of that person's right to emigrate, an appreciable decline in their circumstances?

In the case of persons with a tertiary education, those who have been prepared for professional service by 15 to 20 years of education, their emigration takes with them the expensive training afforded them by the institutions and governments of their home countries. Those investments are made, in part, to improve the living conditions of the collective citizenry of the country. Educational investments are afforded by a collective contribution of taxes and donations by all (or many) of a state's citizens, as tuition almost never pays the full cost of an education in any country. So how do we balance the rights of individuals to move about the globe in pursuit of their own happiness with the needs of the communities that have equipped them for their mobility?

First, we must understand that physicians trained in low-income countries are as rational as anyone. In the summer of 2006, I led a study of health worker motivation, satisfaction and intent to stay for the Ministry of Health in one of the East African countries most likely on Starfield and Fryer's list. We surveyed and held focus groups with hospital-based physicians across the country. We heard repeatedly that working conditions are so dismal, compensation is so low, and opportunities for advanced training so stunted that physicians cannot help but be lured by the greener pastures, as they call them, in wealthy countries. These physicians described circumstances where the hospital has no electricity (and, for example, no operating room lights) for long periods. One large regional public hospital has not had a working x-ray machine or ambulance for more than a year. Running water is not available in a number of hospitals. Fewer than one-half said access to drugs, equipment, and supplies was adequate. One physician said her hospital had a single oxygen tank, requiring daily decisions about which patients would be selected to live and which to die.

When foreign-trained physicians come to the United States, they almost always are required to complete a US residency training program as a condition of state licensure.[2] Many have already completed residencies in their home countries, but even a residency position here earns more money than a medical faculty position at home, so graduates have little reluctance to repeat their training. Many participate in the post-match scramble, relegating them to the specialty choices that remain after US graduates have had their pick. Now that primary care residencies are so unpopular, they are more available to international medical graduates (IMGs).

Even so, that discussion is about physicians' personal choices. Those of us benefiting from their decisions to come practice in the United States have our own set of choices.

Starfield and Fryer refer to the policy opportunities available to wealthy countries to reduce their magnetic pull on physicians in poor countries. In the United States, the primary policy vehicle for luring foreign-trained physicians is the Medicare subsidy on residency training positions that ensures there are 27% more residency positions available than the number of US medical school graduates each year.[3] This arrangement is tolerated by all, including physician guild interests, because it is widely understood that those IMGs are employed in America's large, urban, hospital emergency departments, where copious amounts of primary care and long-delayed attention to chronic conditions are meted out to America's poor and uninsured populations. Indeed, the top physician-importing states from Africa are New York, California, Texas, Maryland, and Illinois—all states with big inner-city hospitals.[4]

Further, when they're done with their training, accomplished while on a J-1 training visa, physicians can get a waiver of their visa return-home requirement if they agree to practice in a rural area, thus again contributing to the care of America's underserved populations.[5] This option has created a growing number of what can be called third world villages in the rural United States, staffed entirely by rotating J-1 visa waiver physicians who provide the only available care.[5]

The United States could address the factors of low pay and poor working conditions in low-income countries, in part by reversing the externally imposed public austerity programs of the international monetary institutions that we lead or control. These International Monetary Fund and World Bank policies of market fundamentalism have restricted the amount of public spending allowable in highly indebted poor countries, especially for health care and education, to increase their capacity to repay debts.[6] Reversing these policies could free up resources to increase the pay rates of health care clinicians and improve working conditions.

The United States has long profited from the fruits of the reverse foreign aid we enjoy by avoiding the cost burden of training all our own physicians or the political burden of better controlling the distribution of those physicians. In his white-follows-green essay, Fitzhugh Mullan points to the adage that, absent a public policy motivating other choices, physicians follow the money.[7]

In another article in this global poverty theme issue of the *Annals*, Robert Ferrer reports evidence that family physicians see almost one-half of the Americans who sought medical care in 2004 and are the only physician specialty group that sees its share of less-affluent people.[8] As a declining portion of US-trained physicians fills the ranks of family medicine practitioners, and as physicians trained in low-income countries fill the gap, we continue to exacerbate the economic and health care access inequities in the United States and abroad.[2] The US Council on Graduate Medical Education has predicted the United States will be short about 85,000 physicians by 2020.[9] In response, the Association of American Medical Colleges has recommended an increase in medical school class sizes,[10] but state legislatures have not yet stepped up to meet the cost of those class size expansions.

Despite Immanuel Kant's groundbreaking ethical assertion in 1784 that common ownership of the earth entitles world citizens the right to free movement, it would be ideal if most people were content in their own countries so that few would migrate.[11] Liberal democratic states that confront big immigration pressures, then, would do best if they adopted policies addressing the root causes of poverty, unemployment, working conditions, pay structures, natural disasters, disease, war, and repression that create much of the desire for migration. Despite its idealistic ring, such an approach (coupled with a commitment to invest in the medical education of our own citizenry[12]) might be the most efficient and practical policy to pursue in the long run.

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