

The Ethics of Physician Migration And the Implications for the United States

Daniel D. Bohl¹

Abstract:

Currently, the United States trains only three quarters of the physicians it requires to fill its entry-level residency positions. The other quarter of residents employed by its hospitals is composed of immigrants who have been trained in other countries. This reliance of our healthcare system on foreign physicians puts a tremendous strain on the healthcare systems of developing nations. At the same time, by replacing American medical school graduates with graduates of foreign schools, the policy prevents a significant number of Americans who desire to practice medicine from doing so. An alarming shortage of physicians by the year 2020 has been forecasted. Discussion of how this shortage will be addressed is long overdue. The options are clear: either the United States can increase its dependence on foreign medical training programs or it can expand its own. It should choose the latter.

¹ Daniel Bohl is a Biological Sciences major, Global Health Studies minor at Northwestern University in Evanston, IL. He will graduate in June of 2008 and subsequently begin a master's program in International Health Policy at the London School of Economics. He can be contacted at d-bohl@northwestern.edu.

Introduction:

Professional migration has been an on-and-off topic for several decades. Recently, a new debate with respect to physicians has brought the topic once again into the spotlight.

There is no question that professional migration is harmful to developing nations. Their governments make investments in the education of their people, only to have those people (and the investments in them) leave to pay off somewhere else. For the most part, however, there is a consensus among scholars that none of the actions on the parts of any of the parties involved are unethical; these arguments are justified by invoking the rights to the freedom of movement and the freedom of trade.

However, this paper argues that with respect to *physician* migration, one action taken by developed nations *is* unethical: developed nations intentionally generating a demand for physicians from developing nations. Developed nations, it will argue, should expand their physician training programs to generate enough physicians so that the luring of human capital from developing nations is no longer necessary. While physician migration is obviously a very complex issue with work required from many different parties for a total solution, this paper decidedly limits its scope to the development of a policy prescription to the United States.

The paper will begin with a summary of the current international situation, its causes, its consequences, and its projected future. This summary will serve as background for a discussion on the ethics surrounding the issue. Finally, the conclusions of this discussion will be applied to the policies of the United States government.

Background:**Physician Migration and Imbalance: Causes, Consequences, and Future**

When, in a classroom of Ghanaian medical students in Accra, students were asked how many of them would like to go abroad for further study after graduation, virtually every hand went up. When they were asked how many thought they would later return home, half of the students' hands went back down.² A great number of the student-physicians in which Ghana invests do not intend ever to practice in Ghana; instead, they envision their futures in New York, London, and Chicago.

A total of one half of Ghanaian physicians practice abroad, with 20% in the United States and another 10% in the United Kingdom.^{3,4} Ghana is not unlike other developing nations: 70% of physicians trained by Zimbabwe in the 1990s have since left.⁵ 60% of Liberia's physicians practice in the United States or the United Kingdom.⁶ 120,000 doctors currently address the needs of the 900 million people on

² Mullan F. (2007). Doctors and soccer players – African professionals on the move. *New England Journal of Medicine*. 356;6.

³ Mullan F. (2007). Doctors and soccer players – African professionals on the move. *New England Journal of Medicine*. 356;6.

⁴ Teferra D. (2000). Revisiting the doctrine of human capital mobility in the information age. *Regional Conference on Brain Drain and Capacity Building in Africa*. February 22-24. Economic Commission for Africa, IOM, International Development Research Centre: Addis Ababa, Ethiopia.

⁵ Saravia NG, Miranda JF. (2004). Plumbing the brain drain. *Bulletin of the World Health Organization*. 82:608-615.

⁶ Gupta R, Hotez P. (2006). Rethinking global health training in North America. *Medscape General Medicine*. 8(3);47.

continent of Africa, a physician to population ratio of 13 to 100,000.⁷ The number of physicians in the United States, the United Kingdom, Canada, and Australia per 100,000 population are 293, 231, 220, and 271, respectively, approximately 20 times higher than the African physician population ratio.

The Causes of Physician Migration

The push. Conditions in which doctors working in developing nations live and practice contribute to their desires to leave. Some of the conditions regularly cited include financial insecurity, political instability, and inadequate educational institutions for their children. Physicians practicing in low-income countries also receive relatively low compensation and must deal with shortages of supplies and extremely high workloads. Opportunities for continued education within those countries are sparse.

The pull. A great attractive force draws physicians towards developed nations. The contrasts abound: physicians who migrate to developed nations share in the higher standard of living of those nations and benefit from greater financial and political stability; their children receive a better education and have greater professional opportunities; the relative abundance of high-tech equipment, medical supplies, and support staff; a much better physician to patient ratio make for far more satisfactory work conditions; and opportunities for continued education are widely available.

A second factor is a necessary contributor to the pull: high physician demand in the physician-receiving country. This demand exists in developed nations including the United States, the United Kingdom, Canada, and Australia because these countries consistently train fewer physicians each year than their healthcare systems require. They do so because allowing already trained physicians to cross their borders is less expensive than training physicians domestically. The influx of already-trained physicians represents an influx of human capital with no monetary exchange. This induced shortage draws in physicians from less developed nations all over the world.

The Consequences of Physician Migration and Imbalance

For developing nations. As stated, 50% of Ghana's physicians currently work abroad. While these doctors make up only small percentages of the workforces of the developed countries in which they practice, they comprise a tremendous loss to Ghana's increasingly strained healthcare system.

The major consequence of this loss is a dramatic decrease in the availability and quality of healthcare. Fewer doctors means fewer patient visits, less time with patients, more expensive care, and higher rates of disease.

The second consequence is the loss of considerable investment on the part of developing nations. While not always a tremendous loss in income for a developing nation due to the significant amount of money that finds its way back in the form of remittances, an individual migration always represents a tremendous loss in human capital. The United Nations Commission for Trade and Development estimates that each professional leaving Africa costs the continent US\$ 184,000.⁸ This is money lost by healthcare

⁷ Rodnick JE. (2006). Africa: Some thoughts on the medical brain drain. *Family Medicine*. 38;1

⁸ Marchal B, Kegels G. (2003). Health workforce imbalances in times of globalization: Brain drain or professional mobility?. *International Journal of Health Planning and Management*. 18:S89-S101.

systems that could be better spent on desperately needed medical supplies and support staff, and it is money that could be better spent on training physicians to practice at home.

For developed nations. Ironically, the countries with the strongest healthcare systems benefit from physician migration. Developed nations save millions of dollars by relying on foreign-trained physicians to fill the gap between the number they need and the number they train.

The future of physician migration

Studies forecast shortages of as many as 20% of physicians in the developed world by 2020 or 2025⁹. This represents 40 times the current yearly immigration rate. While decisions on how to manage these shortages have not yet been made, the choices presented to developed nations are clear and defined: developed nations must either expand their physician training programs or increase their reliance on the workforces of developing nations.

The Ethics of Physician Migration:

Physicians as Human Capital on the Free Market

To talk about physicians on the free market may not be entirely appropriate, but it does provide a useful framework for a discussion of their demand, as well as for the investments made in their training and practice.

No country wants to train doctors. For wealthy nations, it is cheaper to allow them in from poorer ones; for poorer nations, it is extremely costly to have them leave for wealthier ones. With demand for physicians high in both groups, the wealthier nations with the thicker pocketbooks receive a major influx. In contrast, developing nations are left to train a higher number each year in order to retain a suitable workforce.

This is a win-lose situation for the nations involved, not an equal exchange, because, unlike in free trade involving goods, developed nations do not pay developing nations upon acquiring their ‘product.’ These investments pay out only if the resultant capital remains in the investing country. When developed nations acquire the workers of developing ones, they essentially deprive developing countries of these investments.

However, specific rights of developed nations justify this seeming robbery in the instance that it is not pre-meditated. In other words, developed nations have a right to be self-serving when they find themselves in need, and they have a right to see unanticipated shortages in their workforce corrected. In times of shortage, developed nations are justified in allowing foreign physicians to fill their gaps, even if it means drawing from more needy developing ones.

The direct harm principle. While it may be ethical for developed nations to fill *unanticipated* physician shortages because of their right to self-service in a time of need, it is not ethical for them to use physician immigration as a long-term, cost-cutting solution.

The direct harm principle makes this dependence unethical. In other words, the free market is allowed to run “free” except when it causes *direct harm* to individuals. For example, the drug trade (both

⁹ Cooper, RA. (2002). Economic and demographic trends signal an impending physician shortage. *Health Affairs*. 21;1.

legal and illegal) is regulated everywhere, and the sale of organs is prohibited in nations around the world. These regulations of the free market protect one or more of the parties involved in the would-be transaction.

The emigration of physicians, unlike that of other professionals, causes a direct and immediate harm to individuals. Physicians are direct caregivers. When a physician leaves, individuals who desperately need treatment go without the very services they need. The people of developing nations are directly and immediately harmed by the action of the free market. Regulation of the free market in this situation is consistent with regulation in other instances.

Physicians as immigrants

Immigration is tolerated when the economy is strong, jobs are in surplus, and human labor is in need. Employed by the businesses of developed nations, immigrants provide the economies of those nations with the means by which to grow.

On the other hand, when the economy is weaker and unemployment is high, immigration takes on a different light. Many nationals accurately perceive it as an influx of foreign workers who will compete for jobs. During these times, immigration law takes a more conservative stance: policies are tightened and immigration is restricted.

In this sense, the “economy” is “strong” right now from the perspective of physicians in the developed world. There is a high demand/supply ratio for their service. In response, developed nations have opened their doors to immigrant doctors in order to fill their shortages and satisfy the needs of their publics. This is entirely consistent with immigration policy in other spheres and with that which is generally accepted.

However, while the demand/supply ratio for trained physicians is high, that ratio for another group of nationals, domestic premedical students, is, in contrast, low. In the United States, for example, medical school admissions rates are as low as 3%, with less than half of applicants accepted annually to the schools to which they apply.¹⁰ These 21- to 30-year-olds desire nothing greater than to help fill their nations’ physician shortages. Yet, there are not enough spaces in medical school classes to allow them to do so. Medical school admission is the bottleneck that prevents these nationals from getting work.

By replacing would-be domestic medical school graduates in the workforce, immigrant doctors essentially impede potential medical students from obtaining employment. As discussed, situations that result in competition between immigrants and domestic workers generally result in a tightening of immigration policy designed to protect the jobs of nationals.

The requirements of current physician workforce demand and medical student workforce demand directly conflict. High demand for physicians requires immigration law to relax to increase the number of physicians. Yet, low demand for medical students requires the opposite to happen to ensure that young nationals are not put out of work. How can these two requirements be reconciled?

¹⁰ Applicants, accepted applicants, and matriculates by sex, 1995-2006. (2007). *American Association of Medical Colleges*. Retrieved May 28, 2007, from <http://www.aamc.org/data/facts/2006/2006school.htm>.

Governments must first ensure that more domestic premedical students are admitted into the physician workforce through the expansion of medical schools. In other words, it is the responsibility of a government to first find jobs for its own citizens. Nonetheless, medical school expansion and physician training are slow, so the increase in physicians will not be felt in the workforce for a number of years. During these years, the immigration of foreign doctors is acceptable because it does not compete with domestic medical school admissions. Once the result of training expansion is felt, immigration policy should be tightened so that medical school admissions can be kept at a maximum.

The government can and should use physician immigration to satisfy short-term need, but over the long run, the government should protect the jobs of nationals by expanding medical school classes and replacing the immigration of foreign-trained physicians with the resulting increase in domestic graduates.

Discussion:

The two ethical analyses conclude that, while it is ethically acceptable for developed nations to draw on the supply of physicians from developing nations to fill unanticipated, short-term shortages, it is not acceptable for them to do so as part of a premeditated, cost-saving strategy that puts would-be physician-nationals out of work. Rather, developed nations should expand their physician training programs so that the luring of human capital and replacement of nationals in the workforce is no-longer necessary.

Impending Physician Shortage

The last major debate over physician shortages took place in the 1950s and 1960s. This debate, instigated through the Education Assistance Act of 1963, led to the opening of forty-three new medical schools between 1956 and 1980. During this time, the number of first-year enrolled students more than doubled from approximately 8,000 to 16,590.^{11,12}

In the early 1980s, the academic pendulum swung in the other direction. A major physician *surplus* was forecasted to present itself with the new millennium.^{13,14} The federal government responded by drastically cutting funding for medical education. Medical schools stopped growing their class sizes and the number of enrolled students entered a period of zero growth that would last for the next twenty years.¹⁵

However, the forecasted surplus did not materialize with the onset of the new millennium. In fact, demand for physicians remained high. This startling result prompted the undertaking of new modeling projects that have forecasted not a surplus but an alarming shortage over the next twenty years. One of these new studies published in 2002 predicts a shortage of as many as 200,000 doctors, or 20% of the

¹¹ Cooper, RA. (2002). Economic and demographic trends signal an impending physician shortage. *Health Affairs*. 21;1.

¹² U.S. medical school applicants and students, 1982-83 to 2006-2007. (2007). *American Association of Medical Schools*. Retrieved on May 29, 2007, from www.aamc.org/data/facts/start.html.

¹³ Summary report of the Graduate Medical Education National Advisory Committee. (1980). Vol 1. Washington, DC: Government Printing Office.

¹⁴ Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services. (1981). Washington: *US Department of Health and Human Services*.

¹⁵ Cooper, RA. (2002). Economic and demographic trends signal an impending physician shortage. *Health Affairs*. 21;1.

physician workforce by 2020 or 2025.¹⁶ The authors expect that this shortage will be felt both in specialties and in primary care.

Since the release of this compelling evidence, the major interested advisory groups have all reversed their opinions. Both the American Medical Association (AMA) and the Association of American Medical Colleges have stated their belief that the previously feared surpluses are not likely to materialize^{17,18} and the Council on Graduate Medical Education (COGME) has reversed its stance entirely, declaring instead that physician shortages are imminent.¹⁹

The Response of Other Developed Nations

Predictions of shortages are not unique to the situation in the United States. Similar shortages are predicted in the United Kingdom, Canada and Australia. But these countries, unlike the United States, are actively addressing the issue. The United Kingdom plans to expand its physician training²⁰. In addition, Canada has announced plans to open two new medical schools;²¹ and Australia is expanding its medical school capacity by thirty percent.²²

Why the United States Must Act Now

Unless the United States plans to fill this yearly physician shortage with a significantly higher proportion of foreign-educated physicians over the long-term, policymakers must act now to expand the nation's training programs. If they do not act, two decades from now an additional twenty percent of the new physicians each year will need to come from foreign programs, making the total figure fifty percent.

The issue is particularly pressing because of the delay between the action taken to expand training and the resulting increase in the supply of physicians available to the public. The Education Assistance Act of 1963 led to the last major increase in physician training and to a nearly doubling in medical school seats. Yet, it was fifteen years after that legislation was passed before an appreciable increase in the amount of physicians were available to the public. Experts doubt that this process could occur anymore quickly today.²³ With major shortages predicted fifteen years out, now is the time to act.

Conclusion:

¹⁶ Ibid.

¹⁷ AMA revises policy to address continued demand for physicians. (2003). *American Medical Association*. Press release. December 9.

¹⁸ Consensus statement on physician workforce. (1997). American Association of Colleges of Osteopathic Medicine, American Medical Association, American Osteopathic Association, Association of Academic Health Centers, Association of American Medical Colleges, National Medical Association. Washington, DC: Association of American Medical Colleges.

¹⁹ Reassessing physician workforce policy guidelines for the US 2000-2020. (2003). *Council on Graduate Medical Education. US Department of Health and Human Services*.

²⁰ Cooper, RA. (2004). Weighing the evidence for expanding physician supply. *Annals of Internal Medicine*. 141:705-714.

²¹ Chan B. (2003). Physician workforce planning: what have we learned? Lessons for planning medical school capacity and IMG policies. The Canadian perspective. *Proceedings of the 7th International Medical Workforce Conference, 11-14 September*. Oxford, United Kingdom.

²² Gavel P. (2003). Physician workforce planning: what have we learned? An Australian perspective. *Proceedings of the 7th International Medical Workforce Conference, 11-14 September*. Oxford, United Kingdom.

²³ Cooper, RA. (2002). Economic and demographic trends signal an impending physician shortage. *Health Affairs*. 21;1.

Both because it causes a direct harm to individuals in great need and because immigrant physicians replace Americans in their own job market, United States policymakers must take action to reduce the country's dependence on physicians trained in other countries. The only ethical solution is to expand domestic physician training. In order for the effects of this policy to be felt before the physician shortage gets too severe, action must be taken immediately.

The inaction of United States policymakers with respect to this issue represents a failure on their part, but the United States remains in a position to act. Policymakers should immediately pass legislation similar to that passed in 1963 that would facilitate the training of more United States medical students and reduce its dependence on physicians trained in the developing world.

References:

- AMA revises policy to address continued demand for physicians. (2003). *American Medical Association*. Press release. December 9.
- Applicants, accepted applicants, and matriculates by sex, 1995-2006. (2007). *American Association of Medical Colleges*. Retrieved May 28, 2007, from <http://www.aamc.org/data/facts/2006/2006school.htm>.
- U.S. medical school applicants and students, 1982-83 to 2006-2007. (2007). *American Association of Medical Schools*. Retrieved on May 29, 2007, from www.aamc.org/data/facts/start.html.
- Consensus statement on physician workforce. (1997). American Association of Colleges of Osteopathic Medicine, American Medical Association, American Osteopathic Association, Association of Academic Health Centers, Association of American Medical Colleges, National Medical Association. Washington, DC: Association of American Medical Colleges.
- Chan B. (2003). Physician workforce planning: what have we learned? Lessons for planning medical school capacity and IMG policies. The Canadian perspective. *Proceedings of the 7th International Medical Workforce Conference, 11-14 September*. Oxford, United Kingdom.
- Cooper, RA. (2002). Economic and demographic trends signal an impending physician shortage. *Health Affairs*. 21;1.
- _____ (2004). Weighing the evidence for expanding physician supply. *Annals of Internal Medicine*. 141:705-714.
- Gavel P. (2003). Physician workforce planning: what have we learned? An Australian perspective. *Proceedings of the 7th International Medical Workforce Conference, 11-14 September*. Oxford, United Kingdom.
- Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services. (1981). Washington: *US Department of Health and Human Services*.
- Gupta R, Hotez P. (2006). Rethinking global health training in North America. *Medscape General Medicine*. 8(3);47.
- Marchal B, Kegels G. (2003). Health workforce imbalances in times of globalization: Brain drain or professional mobility?. *International Journal of Health Planning and Management*. 18:S89-S101.

- Mullan F. (2007). Doctors and soccer players – African professionals on the move. *New England Journal of Medicine*. 356;6.
- Reassessing physician workforce policy guidelines for the US 2000-2020. (2003). *Council on Graduate Medical Education. US Department of Health and Human Services.*
- Rodnick JE. (2006). Africa: Some thoughts on the medical brain drain. *Family Medicine*. 38;1
- Saravia NG, Miranda JF. (2004). Plumbing the brain drain. *Bulletin of the World Health Organization*. 82:608-615.
- Summary report of the Graduate Medical Education National Advisory Committee. (1980). Vol 1. Washington, DC: Government Printing Office.
- Teferra D. (2000). Revisiting the doctrine of human capital mobility in the information age. *Regional Conference on Brain Drain and Capacity Building in Africa*. February 22-24. Economic Commission for Africa, IOM, International Development Research Centre: Addis Ababa, Ethiopia.