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CONLEY ESSAY

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Stuffing Mouths with Gold: Equitable Solutions to the Primary Care Physician Shortage

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State University Medical School's explicit, community-based mission is to educate primary care physicians for its home state, which comprises mainly small towns and rural areas.

As its fortieth anniversary approached, State U. Medical School administration reviewed alumni data and realized that the school had not come close to fulfilling its mission. The school required those who received financial aid to complete residency in a primary care specialty within the state. If they did so—and most did—their loans were forgiven. But the alumni data showed that, over the years, an average of 60 percent of residents had gone on to fellowships in subspecialties immediately after residency, and many of those had moved out of state to practice.

As a corrective to this “mission slippage,” a new policy for state-funded loans and privately funded scholarships was proposed such that students who declared their interest in practicing primary care in the state and received full tuition from state or private sources had to practice primary care in the state for 10 years after completion of their residencies to repay the cost of their medical education. There was a sliding repayment scale based on service increments of 1 year for those who practiced primary care in-state but did not fulfill their 10-year service agreement.

Several of the school's private funders objected to the proposed policy; at least one was outraged.

“I've always supported our mission,” he said, “but this new policy is coercive. It's social engineering, is what it is. Flies in the face of everything this country and this state stand for. When my grandfather came to this state in the early part of the last century, a man could make his living any way he wanted to, long as he didn't break the law.”

“What's worse,” the funder continued, “is that this policy hurts the middle- and low-income kids. The rich kids don't need our support, so they can practice anything they want, anywhere they want.”

Response

As the cost of an American medical education ascends to eye-watering levels (the mean indebtedness upon graduation reached \$158,000 in 2010 [1]), it is tempting to heartily embrace any action that promises to ease the financial burden on the nation's future physicians. Moreover, as increasingly urgent analyses predict massive shortfalls in the primary care workforce, exacerbated by the demands of caring for millions of newly insured patients under the Patient Protection and Affordable Care Act (ACA) [2], a scheme that offers to bolster the ranks of primary care physicians appears doubly attractive.

Yet the seductive proposal advanced by State U Medical School masks an unpleasant consequence—the stratification of young physicians on the basis of inherited wealth. The emergence of such a hierarchy rooted in socioeconomic status motivates the objection of the private funder presented in the scenario. In this essay, I seek to explore that objection philosophically. Doing so requires addressing two related yet distinct questions. First, on what grounds is this policy subject to *moral* scrutiny? Second, if this policy indeed turns out to be morally objectionable, do alternative options exist to fulfill the goals of the medical school? I probe the first question using the concept of “capabilities” to provide firm foundations for a moral protest. In response to the second question, I argue that this policy in fact fails to address the structural problems at the heart of the primary care physician shortage. Instead, I propose a path that attempts to harmonize with the ongoing shifts in health care policy and the implementation of the ACA.

First, to draw out points of objection clearly, I will briefly recapitulate the school's proposed policy. A key goal of this medical school is to graduate physicians who will go on to practice primary care medicine within the state. The school's administrators have attempted to achieve this aim by offering financial aid conditional upon students' remaining in the state as primary care doctors. They have discovered, however, that this approach has failed, as many graduates accept the financial aid but leave the state anyway and pursue more profitable subspecialties. To solve this problem, the school administrators have proposed a policy in which the amount of assistance in the form of loan forgiveness varies based on the number of years (up to 10) the graduate spends in primary care practice. The financial aid enforcement now comes with teeth.

To simplify the argument and sharpen the focus on the *moral* problem at hand, I make three general assumptions: First, the students are committed to practicing medicine, and State U Medical School is their only option. Thus, tweaking financial aid policies will not be sufficient to either drive students to another medical school or away from medicine altogether. Second, wealthy individuals, possessing the means to pay off loans without assistance, will reject a coercive policy and will choose whichever specialty they desire. Given the current trend of graduates from State U Medical School, greater numbers of these individuals will be likely to pursue subspecialties rather than primary care. Third, low- and middle-income individuals, facing a significant debt burden and lacking the family means with which to service

it, will most likely choose to pursue primary care. These assumptions are neither perfect nor rigid, but they provide a broad framework within which to assess the school's policy. The latter two assumptions essentially capture the objection of the private funder—the choice of a medical graduate's specialty becomes limited by economic means. Below, I explore that consequence, arguing that it is open to moral objection. Following that, I argue for an alternative approach that addresses the structural causes of the shortfall of primary care graduates and *incentivizes* rather than coerces medical graduates to pursue careers in primary care.

Though various philosophical tools are available with which to examine such a policy, here I focus on the concept of capabilities. Generally speaking, by capabilities I mean both the resources (understood expansively to include wealth, education, social status) *and* the ability (encompassing areas such as health, individual liberty, etc.) that an individual possesses with which to achieve his or her goals. Such an approach represents a marked shift away from thinking exclusively in terms of resources, exemplified by Rawlsian primary goods and, to a certain extent, utilitarian reasoning. A major benefit of using capabilities is that it also factors in an individual's ability to *convert* resources into achievable ends.

A comprehensive assessment of an individual's relative advantages and disadvantages is hardly a new idea. As Aristotle noted in the *Nicomachean Ethics*: “wealth is evidently not the good we are seeking; for it is merely useful and for the sake of something else” [3, 4]. Therefore, by focusing on the *capabilities* of individuals rather than purely their resources, we are able to capture a broader set of characteristics that allows us to more intelligently compare them. For example, an extremely wealthy yet physically handicapped person may, in comparison to an able-bodied, middle-class individual, possess far more resources yet lack the ability to convert those resources as effectively into achievements.

The concept of capabilities proves particularly useful in assessing the moral foundation of the medical school's policy. We may reframe the overarching question as the following: does the medical school's policy truly and disproportionately restrict the *capabilities* of one group of students to the advantage of another? Superficially, no. We may defend the policy on three major flanks. After all, the medical school is still offering the same basic resource to all students—a medical education. The school is not deliberately attempting to curtail anyone's capability to *convert* that resource into a successful career. Moreover, the available financial resources in the form of loan forgiveness are being distributed specifically to lower- and middle-income individuals. Therefore, if anything, the school is actually contributing toward an *equalizing* effect with respect to individual wealth. Finally, the school is not explicitly prohibiting anyone from choosing a particular specialty upon graduation. That certain financial incentives are being offered to nudge people in one direction or another is not equivalent to forcible compulsion. Students must simply be willing to accept the financial consequences of turning down conditional aid.

While reasonable, this defense ignores the fact that the medical school's policy represents a more insidious form of discrimination, one that becomes evident when capabilities are considered in a deeper sense. Based on the assumptions provided above, the school's policy effectively guarantees a general (though not perfect) stratification of medical careers on the basis of socioeconomic status. Critically, those low- and middle-income people who may have wanted to pursue a higher-paying subspecialty will be shuttled into a path that avoids initial debt but forgoes higher lifetime earnings. Not every student will follow this trajectory, but State U's experience thus far suggests that most will. In so doing, the school has subtly and specifically restricted the capabilities of poorer students to pursue their field of choice, and wealthier students are equipped with a significantly broader set of capabilities. A poor student graduating from State U is less capable of becoming a surgeon, for example. Though individual tolerance for inequality varies widely, this policy is demonstrably vulnerable to reasoned objection on moral grounds.

One key rejoinder, however, is that individuals from poor backgrounds will still be physicians (perhaps the first in their families) and will earn substantially more over their lifetimes than their parents. In effect, this line of reasoning concludes that some degree of *relative* socioeconomic inequality is acceptable because it provides advancement in *absolute* terms for lower- and middle-income individuals. The capabilities of poorer individuals are greater than those of their parents. Such an argument is fragile, because it not only permits and perpetuates an income inequality gap but also widens it. In 2010, the median compensation of radiologists and orthopedic surgeons was approximately \$350,000 [5], while that of primary care physicians was \$159,000 [5]. Though hardly a salary that will generate sympathy, these physicians still earn less than half of the income of certain subspecialized counterparts. While individuals from lower- and middle-income households *will* rise socioeconomically, this policy enables wealthier individuals to accumulate substantially more wealth and relegate poorer individuals to a lower income. Therefore, the school may be equalizing some resources, but the long-term capabilities of poorer individuals remain hobbled by this policy.

It is worth pointing out that not all (indeed, perhaps few) decisions of specialization are undertaken purely on the basis of financial compensation. Medical graduates continue to forgo higher salaries and pursue primary care out of a passion for serving neglected communities, the opportunity to build long-term relationships with patients and families, and the intellectual challenge of serving as gatekeeper to the medical specialties, requiring broad-based knowledge of medicine. Yet it is also true that, left unchecked, the shortage of primary care physicians will become increasingly critical. If the medical school's policy of "pushing" individuals into primary care is ultimately discriminatory, perhaps a policy of "pulling" will do the trick. We cannot deny the dismal maxim that economic incentives matter. Consider Aneurin Bevan's crisply world-weary description of how he successfully convinced Britain's senior physicians to sign on to the formation of the National Health Service—he had "stuffed their mouths with gold." Though most future physicians are motivated by the desire to serve, the altruism of graduates does not provide a sustainable strategy.

In the remainder of this essay, I argue for an alternative proposal that seeks to redress inequities on the basis of socioeconomic status while still promoting careers in primary care.

As a “pull” approach rather than a “push” approach, the idea is to boost the attractiveness of in-state primary care as a career. Much of the required action can be taken by the medical school and its academic medical center, though some will, of course, depend on the direction of health policy on a national level. First and foremost, while acknowledging the limited pot of scholarship funds available to the school, that budget should be redistributed purely on the basis of financial need. Rather than making funds contingent on an individual’s future choice of specialty, scholarship funds and loan forgiveness options should be disbursed in accordance with an individual’s ability to pay. This policy will solve the problem of economic discrimination but cannot be implemented in isolation because it may discourage the pursuit of primary care.

The larger problem, that of rebalancing the medical workforce toward primary care, is a structural one and requires more than patchwork initiatives. A sustainable solution demands more than punitive financial pressure—instead primary care must be reconfigured into an attractive path on similar footing with subspecialties. The medical school can take tangible steps toward achieving this goal while moving in accord with the changes in the American health care system arising from the ACA.

One of the boldest reforms set forth by the ACA is the promotion of accountable care organizations (ACOs), within which clinicians contract to deliver coordinated care, with the aim of eventually supplanting fragmented fee-for-service care with outcomes-based care, prioritizing quality over quantity of service. Such an approach, in theory, keeps people healthier by focusing on preventive care, in turn lowering health care costs. The formation of accountable care organizations is encouraged by allowing clinicians to share in the savings generated by this approach to care. It is important to note that the obstacles to accountable care are non-trivial—recent studies have demonstrated the substantial investment required of hospitals and physician groups in ACO pilot programs [6] and the large increases in reimbursement demanded by physicians to switch from a fee-for-service model toward an ACO model [7]. Yet with the familiar refrain of unsustainable health care costs, the question is not whether such reforms ought to be implemented, but whether they will be adopted swiftly, with sufficient freedom of action to tweak and adjust, or if they will be thrust upon a system ravaged by savage cuts in the future.

Given this narrow range of options, State U Medical School is well-placed to position itself as a vanguard for the changing model of American medicine. Over time, the hope is that individuals will become healthier, costs will diminish, and reimbursement rates for primary care physicians and subspecialists will move toward convergence. In such a scenario, primary care will begin to become a more attractive career option independently, but the medical school can implement its own solutions to accelerate this rebalancing. First, by incorporating as an ACO, the medical center

associated with the school will begin to change its own practice patterns, a transformation that will necessarily trickle down to students as they enter the wards. Students whose first exposure to medicine in their clinical clerkships includes coordinated care in which primary care physicians function as the “quarterbacks” will naturally begin to see career options differently from previous generations. Second, and more controversially, the medical school can adjust its own residency training plans, preferentially selecting in-state applicants for instance. Finally, the academic medical center can begin to alter its own incentive structures for faculty physicians to promote primary care.

Change will not come easily. But overall, the state and the nation would be well served by intelligent policies that solve the structural problems of primary care medicine *and* offer low-income students the opportunities of the wealthy.

References

1. Greysen SR, Chen C, Mullan F. A history of medical student debt: observations and implications for the future of medical education. *Acad Med.* 2011;86(7):840-845.
2. Cohen SA. A review of demographic and infrastructural factors and potential solutions to the physician and nursing shortage predicted to impact the growing US elderly population. *J Public Health Manag Pract.* 2009;15(4):352-362.
3. Aristotle. *The Nicomachean Ethics*. Ross D, trans. New York: Oxford University Press; 2009: 7.
4. Sen A. *The Idea of Justice*. Cambridge, MA: Belknap Press of Harvard University Press; 2009: 253.
5. Guglielmo W. Introduction. *Medscape Physician Compensation Report: 2011*. <http://www.medscape.com/viewarticle/740086>. Accessed July 25, 2011.
6. Haywood TT, Kosel KC. The ACO model--a three-year financial loss? *N Engl J Med.* 2011;364(14):e27.
7. Zweifel P. Swiss experiment shows physicians, consumers want significant compensation to embrace coordinated care. *Health Aff (Millwood)*. 2011;30(3):510-518.

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