

Physician Policymaker Interview Series: Dr. Fitzhugh Mullan

Katie Iossi, M3, University of Iowa Carver College of Medicine, National Delegate for Legislative Affairs - November 2006

This is one in a series of interviews that will examine the careers of physician-policymakers, the state of the healthcare system, and how students can affect policy discussions. All interviews, including this one, will be posted on the OSR Web site. If you have suggestions for future interviewees, comments, or questions, feel free to contact me; katherine-iossi@uiowa.edu

Dr. Fitzhugh Mullan is a leader in health policy, academic medicine, and community health practice. He is the Murdock Head Professor of Medicine and Health Policy at the George Washington University School of Public Health and Health Services, a Clinical Professor of Pediatrics at the George Washington School of Medicine, and a staff member at Upper Cardozo Community Health Center in Washington, DC. Dr. Mullan also serves as an editor for Health Affairs, a premier health policy journal, and has written numerous books and journal articles on his experiences and research. His political appointments have included: U.S. Assistant Surgeon General, Secretary of the Health and Environment Department for the State of New Mexico, a member of the President's Task Force on Health Care Reform, and member of the Council on Graduate Medical Education. In September 2005, Dr. Mullan moderated the AAMC-OSR/AMSA/ACP joint conference on the Financing of Undergraduate Medical Education in Washington.

Q. When and how did you become interested in health policy and affecting change within the healthcare system?

A. I became interested while I was in medical school in the mid-60's when there were strong winds of social change in America. I was caught up in the civil rights movement and went to Mississippi between my first and second years of medical school. This was a transformative experience. I saw people who lacked medical care and a fair shot at becoming part of the healthcare system—what we call “access” today. People didn't have doctors, the system was segregated, and inferior care was given. These people were left out of contemporary medical care. Seeing this called out to my sense of equity and fair play. The situation was patently unfair. I realized that inequity will emerge, somewhat like entropy, if you don't work to fight it off.

When I returned to medical school in Chicago, I realized that healthcare was segregated there as well and that there was plenty to do at home. I got busy organizing colleagues and formed the Student Health Organization, modeled after the World Health Organization, with chapters at most medical schools across the country. We became an active force in community service, curricular reform, and learning about and speaking to policy issues. We focused on big picture issues—on who gets what, where, when, and how. I realized that we students were so busy looking through our microscopes and at our cadavers that we were not looking up and around at the system as a whole, at issues that mattered a lot. Part of my work was to try to get students to look up and at the system. This is where I got job training in health care organizing within an educational setting.

Q. How did your interest in policy and affecting change in the healthcare system manifest itself in your career after medical school?

A. I chose to do my residency in a city hospital system in New York City where public medicine was being practiced. After this, I joined the first class of the National Health Service Corps as a commissioned officer of the US Public Health Service. I was sent to northern New Mexico where I helped found a community clinic and practiced community medicine. We built a good delivery system. Next, I returned to Washington to work in the central office of the National Health Service Corps and was eventually appointed director of the National Health Service Corps under the Carter administration. This was a very exciting time for me. The NHSC was basically a national community service project and a huge resource. It was my first opportunity to be a formal policy-maker. I remained in the Public Health Service until 1996 and my administrative responsibilities gradually increased.

My final appointment was in the Bureau of Health Professions where I focused on medical education policy and was able to disperse a small amount of education funding with a focus on primary care. We were given the opportunity to help build the physician workforce and attempted to give adequate support for the primary care base in this country, which is not fortified. Primary care needs funding and support, it needs distribution incentives. We need to increase money in places where we need doctors and we must practice equity in healthcare. During this period, I was a part of President Clinton's Task Force on Healthcare Reform. We tried to re-craft how public funds were distributed to make major incentives to train more primary care doctors. Though the President's proposal as a whole was defeated, we were able to stir the pot a bit and place emphasis on primary care.

Q. You retired from the government in 1996. How did you pursue your calling when you were no longer in the government?

A. I was very committed to the concept and practice of primary care, so I went back and retrained in pediatrics and since then have worked part time at the Upper Cardozo Community Health Center in Washington, DC seeing patients and teaching medical students and residents. Clinical practice keeps my soul alive and my credibility in tact. I have the gratification of working one-on-one in a medical setting, and I also earn my spurs clinically which improves my standing in policy circles when I talk about "the system." I believe it is good to look up, but good not to give up medical care.

Q. What is it like balancing patient care and policy work?

A. It is hard in some ways. It is tough to travel when I have patients to see and tough to engage in policy battles when I have other commitments. There is definitely some tension there, but I think I do each better because of my involvement in the other.

Q. How have you continued to pursue your goals from medical school in your work at George Washington University?

A. Since the early days in medical school, I have been fascinated by teaching, training, mentoring, and apprenticing, but had never been based in a medical school. When GW

asked me to join them, I couldn't turn them down. I have appointments in both the medical school and the public health school and therefore have the opportunity to teach medicine and health policy. I have also been able to pursue research interests.

Q. What is your biggest concern with the healthcare system today?

A. Currently, it is with the physician workforce: how they are trained and distributed, how many we need and how many we have. One quarter of all doctors practicing in the U.S. went to medical school in other countries. They are an important part of medical practice in the US, but what is the effect of their loss to the countries they come from? Issues of equity in healthcare in America pale in comparison to those of other countries. Here in the U.S. we have 280 doctors for 100,000 people. In Ghana it is 10 per 100,000, and in Tanzania it is 1 per 100,000. This is big time global inequity.

The physician migration problem is about the workforce of the world and the need to build a huge capacity because we are way short. It is the biggest problem facing healthcare in the world today. It is a baseline issue, a catalyst issue. You can't deliver healthcare without people. Finances, ethics, medicines, and technology are all important in healthcare, but without people to lay hands on patients, diagnose, treat, and dispense medications, there is no healthcare. It has become an issue of how do you get people where they are needed and where they are supported.

Q. How did your focus shift from issues of the United States healthcare system to more global issues?

A. The study of the US physician workforce led me to a clearer understanding of the high number of international medical graduates in our country, more than 200,000. This, in turn, led me to ask what the impact of this migration was on the sending countries was. The answer is that it is most punishing to the poorest countries. When we have medical vacancies in our system, we fill them with doctors trained elsewhere. When we fill our vacancy with a doctor from Canada, the Canadians import a physician from South Africa, and South Africa, in turn, admits a doctor from Nigeria, and so on. Our workforce shortage is a destabilizing factor to the rest of the world causing deleterious effects worldwide. This led me to conclude that the most important thing the U.S. can do to assist the health of poor countries is to train enough doctors for the US!

Q. What are your concerns about the US healthcare system?

A. We have enormous resources and very gifted people in both clinical medicine and research, and we have enormous promise. The system, however, is hugely commercialized and highly fragmented, subject to all kinds of pushes and pulls that don't relate to good service delivery. Major disparities exist that are related to wealth and employment. We have a long way to go to rebuild our system, to make it much more effective, and to make the most of our current resources, even while we are in need of more resources. The cost of providing the care we do provide is increasing and pulling resources away from other parts of society that need them. I am very concerned about the future of our healthcare system, a system that is so badly disorganized.

Q. What are students' roles in shaping the healthcare system?

A. Young people enter the health system with their eyes wide open and their senses in tune with what might be. Medical students are not yet bought into the current situation and so are often not content with how the system works. The student voice has been valuable before and is very much needed now: It is the role of students to examine their educations, their hospitals, and their medical schools. Medical care needs to be reconstructed and reprioritized and that's a job for the oncoming generation that will shortly inherit the health care system. We have built a gas guzzler of a medical system and it will be the task of the next generation to recapture medical care for prudence and fairness.

If you are interested in learning more about Dr. Mullan's career or the issue of physician emigration, the following articles are recommended:

1) Mullan, Fitzhugh. On Being a Doctor. *Annals of Internal Medicine* 2004; 141: 818-19.

2) Mullan, Fitzhugh. The Metrics of the Physician Brain Drain. *New England Journal of Medicine* 2005; 353:1810-18.

3) Mullan, Fitzhugh. Doctors for the World: Indian Physician Emigration. *Health Affairs*. 2006; 25(2): 380-93.