Primary Care Cures

Episode 139: Dr. Frank Okosun

Ron Barshop:
Welcome to the only show dedicated to a new way of delivering healthcare. This new model has no name, but let's go ahead and call it direct contracting or digital first care. The new way centers on opting out of the games bigs play with their rigged dice, their crooked game board and their purchased referees. And if you're looking for a future where everyone wins, that's the doc, the consumer, the employer, and with assured amazing outcomes and measurably lower costs that are ranging up to 60%, you're in the right place. I'm Ron Barshop, your host. I'm glad you're here. Welcome to the new healthcare economy.

Ron Barshop:

Wait times are up 30% in metros from the last few years. It averages 24 days now to see a doctor and months to see a specialist sometimes. In Boston, one of the worst cities, the average wait is 52 days to schedule an appointment with a family doc, a derm, a cardio, an orthoped, or an OB-GYN. Gives a whole new meaning to family planning when you have to wait two months to see an OB-GYN, doesn't it? Growing wait times are the best indicator that we are experiencing a shortage of physicians, but remember, there are fixes for this. That's what this show is all about, and a big problem adding to delay these fixes, the Silver Tsunami is the fact that daily, 10,000 baby boomers add to Medicare, and that happens again daily, 10,000 for nine more years. So do 365 times nine times 10,000. It's a big Medicare population that's growing.

Ron Barshop:

This decade, the number of Americans aged 65 and older is going to grow by 55%, so just in the next eight to nine years, and it's going to make the projected shortages that we're talking about and the waits longer, so the shortage are going to get worse. We need two to three times as many services, especially in our older ages, so this again is just sort of magnifying this giant problem, but there's a cure and it comes from three sources. My favorite one is one we're going to talk about today. So telehealth is not what we're talking about today, but it's up 40%. pre-pandemic, it was about a one to 2% utilization and now 40% of all visits are telehealth. It's super efficient because it turns out that 75 to 85% of PCP visits can be handled digitally. So less docs are needed when digital care replaces clunky office visits, and it's a lot more efficient for the doctor and the patient, a lot less for time's sake.

Ron Barshop:

Let's talk about nurses as a second source of the solution that kind of chaps a lot of doctors who still don't want to see nurses with the same scope of practice that they have, but I'm not going to judge that today. But they can now practice in 36 states across the borders, more than doctors can, with these reciprocal agreements that are flowing. So it's even easier opening the flood gates though, for trained doctors that are already here, my favorite solution, what we would call an

international medical graduate, who is our guests today. There's only one way to fix this fast and it's a smart way and already, six states have loosened the regulations so international medical graduates, I'll just call them IMGs, can skip a second residency, because remember, every one of these folks have done a residency already in their home country.

Ron Barshop:

We have over 5,000 annually rejected because they're not getting a match on match day. So foreign MDs with an English competency to practice now can't get a slot, and the slotting has remained static since 1994, 30 years, but here's how hospitals could easily expand slots, because what's happening now is they're billing their residents out at 30 to 40 times what they pay for them, so it's a very highly profitable business for a teaching hospital to have residents. The idea that requires, and that they're addicted to these federal subsidies. There's about $660 million subsidizing the 60 to 65 grand that residents make, so the hospitals have basically no cost of labor and just this 30 to 40 X rolling in for what the cost would be if they were paying it. The simple solution would be teaching hospitals could expand their slots because it's so profitable, anyway, even if they were to pay the lousy 60 grand. And frankly, they're paying their head janitor more than 60 grand a year.

Ron Barshop:

So anyway, the bottom line is enlightened states are now allowing IMGs to skip their U.S. residency as long as they practice with an American doc for three years. If you're from India or Nigeria or Mexico, and you've already done your residency and you've already been trained and experienced, you already know you're the cream of the crop of your country. I mean, it's so hard to get just to that level, the very best to the very best are there, than when they get through their residency, but you just need to learn our ways. Canadian doctors already have a free pass to skip residency, why? Because the AAMC blessed Canada and the AAMC could bless the medical schools overseas tomorrow. So either get another slot and pay for it yourself or get the AAMC to wake up. Those are the two ways. Today's guest, Dr. Frank Okosun has something to say about all this. He's an American born doctor, but he studied in Nigeria when he moved back at 10 years old, and he's now an internal medicine doc, practicing here at Houston. Welcome, Frank, to the show.

Dr. Frank Okosun:

Thank you for having me, Ron.

Ron Barshop:

So what do you have to say about all this stuff?

Dr. Frank Okosun:

Where do I start from? You have gone over so many pressing issues, that we can talk all day about this. I think you hit the nail on the head. The bottleneck is the residency positions. Like you said, there are a lot of highly trained and qualified foreign medical graduates in this country who currently cannot practice because of the bottleneck of no residency positions. The federal government, like you said, had that freeze on the increasing positions. We know that with the baby boomers, we are definitely going to need more doctors, so we can't be going by projections

from '94 when they had a freeze on residency positions. Some states like Texas have tried to increase GME funding and increase residency slots, but unfortunately, their efforts have not been enough. These doctors that we're talking about, these are highly trained foreign medical graduates who have gone through all the requirements.

Dr. Frank Okosun:

They've passed the USMLE Step 1, 2, 3, and a lot of them are doing nonclinical jobs now, whether in research, some are Uber drivers, and this is a big waste of talent because these folks are already trained and ready to go. You said something about some states who have loosened their requirements for some of these doctors to practice without residency. I think it's a first great step, but they also have some restrictions as well. Like I know the state of Missouri, they only accept foreign medical graduates who have graduated in the last three years. On average, it takes the typical IMG about five to seven years to get to the U.S. after graduation, because some of them have mandatory internships and they have to study for their exams abroad, they have to work a little bit, they apply for visas and raise the required funds that they need to get to the United States.

Dr. Frank Okosun:

So it is very, very difficult for an IMG to get to the United States within that three to five year gap, and a lot of the American residency programs are coming up with more strict regulations on how they choose candidates. They want candidates who have graduated in the last three to five years, and like I said with my previous explanation, it's very difficult for them to get here within that timeframe. So it's a difficult conundrum of issues, and I feel so bad because I know some of these doctors who are highly trained. Some of them are my colleagues and friends and I know what they can offer and bring to the table but unfortunately, they cannot. And like you said, other advanced countries like Canada and the UK and even Australia, a lot of these doctors can go straight to work, and the health care in that country is not inferior or substandard to ours, so a lot of food for thought here.

Ron Barshop:

Do you think some of that xenophobia, I mean, it doesn't make any sense that an Australian doctor and a Chinese or Nigerian or Mexican trained doctor, an Indian trained doctor has any less qualifications.

Dr. Frank Okosun:

I think it has to do with the way the system is set up. Unfortunately, America is supposed to be a country of immigrants and built by immigrants, but it's not as easy coming into America to settle down and get acclimatized, compared with other countries like the United Kingdom and Canada. So there's kind of a stigma attached to foreign trained doctors or people with foreign credentials. So a lot of times, a program director, if they have to choose between American grad and a foreign grad with exactly the same qualifications, or even if the foreign grad has higher USMLE scores, they tend to go with the American trained grad because they feel like they are already acclimatized into the system and they know what needs to be done, but it doesn't mean that the American trained doctor is better or superior to the foreign trained physician.

Ron Barshop:

I've worked with partners, Indian doctors and Nigerian doctors, doctors from South America, Central America and Mexico. The most shocking thing is just how hard they work, and this isn't just my opinion. This is a fact. Foreign medical graduates are willing to take, number one, internal medicine is not a popular field and there's tons of internal medicine doctors that are foreign medical. And also, they're willing to go into rural areas. I guess they have to in some states, but they are more willing to work in rural areas which are underserved populations, than American doctors are. So it's just a screaming answer to a giant problem. We have, I think, 15,000 pediatricians backlog that are all IMGs, I don't know how many are family docs or internal medicine docs, but virtually everybody that's trained overseas is internal medicine. Is that right?

Dr. Frank Okosun:

Majority of the case, and like you said, a lot of these physicians are going to require visas and with the H-1B program, they are more willing to work in underserved or rural areas, and they are willing to go into these most needed specialties like family medicine, pediatrics, internal medicines. Because of the increasing student loan dept for our American graduates, in the last couple of years, there has been a shift away from primary care because it's considered less rewarding with a more difficult work-life balance. So it's not uncommon to see majority of American graduates going towards highest paying specialties like radiology, anesthesiology, dermatology, orthopedics.

Ron Barshop:

I'll take it one step further, Frank, is that if you look at the finest schools, the top 20 medical schools and you look at where they're being matched, very, very few are going into primary care. They're may be one or two out of each class, but they're mostly going into the specialties because that's not only where the money is to pay off their student debt, but primary care, that's a lot of work. Everybody else is sending you guys their troubled cases or they're saying after they treat them ,they say treat and handle after I've screwed them up.

Dr. Frank Okosun:

That is totally correct. I've heard of the phrase before that primary care physicians, our reward is not here on earth, it's in heaven.

Ron Barshop:

Yeah. Well look, I have a show called Primary Care Cures. I hear this a lot, but I'm not knocking specialists, but I am saying that foreign medical graduates overwhelmingly make up the gerontologists in this country, and are taking care of the Silver Tsunami in much larger numbers than American, because nobody wants that job. That's not a gig that's as desirable, as you said, as the others.

Dr. Frank Okosun:

Most times, like sometimes I get it from my colleagues who are specialists. They talk to me and say, "Frank, you're a little bit too smart to be in primary care." So primary care is kind of considered that, it's considered like, oh, if you're not able to get into any specialties or if you're

not good enough for this, then you go into primary care. My USMLE scores were way higher than a lot of people who got into specialties, but this is what I wanted to do and I feel like this is my calling, so it's not a situation of, oh, I wasn't smart enough or this was all I could get.

Ron Barshop:

Most primary care docs are also dermatologists and psychologists and fill in the blank. There's a lot of subspecialties that fall under primary care that you guys treat, you treat a much, much broader scope than any specialist.

Dr. Frank Okosun:

That is totally correct. I feel like the jack of all trades, sometimes.

Ron Barshop:

Let's talk about exploitation. I walked into a clinic in the heavily Hispanic part of Houston near one of the airports, and not a single person that worked there spoke English except for the owner, the clinician. And the practice manager didn't, the front desk didn't, none of the patients clearly didn't, they're treating either new immigrants or non citizens at this clinic. So it's a heavy Medicaid clinic, but it's probably also a cash clinic. I'm pretty sure it was a cash clinic, and all of the doctors working there were working at medical assistant wages at 15 to 20 bucks an hour, and they're all trained in Mexico. Now, I know how low the matriculation rates, first of all, how hard it is to get into Mexican medical school, thnn how it is to matriculate from there. Very few percentage that start finish, and here's this guy paying them MA wages and probably doing nothing to accelerate their careers, so I call that exploitation. Do you see some of that yourself?

Dr. Frank Okosun:

Yes, I do. So unfortunately, there's also the increasing cases of Americans actually going to foreign schools because medical schools now in America are very, very competitive to get into, so it's not uncommon to see Americans do their first degree here and go to places like in the Caribbean or Dominican or even Mexico, to do their medical school. And they have to take out loans and take out personal loans and savings to actualize their dreams, and then to come back, and they are actually American citizens, but they're being treated like second-class citizens because they went to go get their degree from a foreign country, so they have to do what they have to do to survive. So some of them, like I said, are Uber drivers, they work on the delivery apps, delivering food.

Dr. Frank Okosun:

So a lot of them, because they do not want to lose those connections with medicine, they take up all kinds of jobs, medical assistants, scribes, some of them try to go into research. So it's very, very tough for these highly trained physicians who are unable to further their career because of the bottleneck of residency. And a lot of them too, are going out to Canada and the UK and other countries, because during the pandemic, the UK, they passed a law that if you have passed your USMLE Step 1, Step 2, Step 3, you can get full registration there as a physician and you can start working immediately. So I think at the end of the day, the U.S. will be on the losing end of the argument, and there will be a lot of brain drain to a lot of other countries like the UK and Canada, who will stand to benefit from the current situation.

Ron Barshop:

Well, again, I like what these five or six states are doing, where they're just suspending the need to have a residency slot and accepting the FMGs on their own merits with three years of standby training with another doctor, because you do have to learn our insurance system. It's quite complex and quite stupid and cumbersome, but you do have to learn how to code and all of that takes some time. So let's talk about the growing problem of retiring doctors. Right now in America, we have roughly 205,000 PCPs and a third of them are over 58 or 59 years old, meaning theoretically they're five years away from retiring.

Ron Barshop:

Most of the doctors I know that are 65 don't need to retire or want to retire because they can basically work as a locums or a lot of medical director, a lot of other different side gigs, and still keep practicing, but maybe not on the hours they were before, the responsibilities they had it before. So we're losing 70,000 people over the next five years, theoretically, and we're only adding 2000 to 3000 PCPs out of the residencies. So we've got not only a grind of a tsunami of silverbacks that are all retiring and going into Medicare, but we also have the same generation is retiring from medicine. So it seems to me like America has to wake up and just sort of change everything about how foreign medical graduates are treated because we're five years away from the crisis. We're not at the crisis level, we're on the edge of the cliff about to fall over.

Dr. Frank Okosun:

That is so true, and I think one of the quick fixes that has been tried to be implemented to fix the issue has been the sudden proliferation of physician assistants, or I think how they wish to be addressed now, physician associates and nurse practitioners. A lot of doctors too, are not even waiting to retirement to retire. Some of them are retiring very early in their late forties and fifties and switching over to nonclinical careers because they are burnt out. The increased documentation and bureaucracy and decreased reimbursements have actually made people have a rethink of their life. There's definitely an increase in physician suicide rates, the COVID obviously did not help, so like you said, this is a serious crisis that's right in front of us.

Dr. Frank Okosun:

I do not have anything against nurse practitioners and physician assistants. I'm actually married to a nurse practitioner, but with a lot of their training, they have less training hours than physicians and a lot of their programs now are online. When the programs actually first started out, there used to be the requirement for the nurses to have five to 10 years of clinical bedside nursing experience, which is very, very vital, but now we are seeing cases where people are just finishing their BSN in nursing and going straight into nurse practitioner school without having the prerequisite clinical experience, which I think is not in their favor. So they do a lot of the programs online, they don't have a lot of clinical hours and clinical experience.

Ron Barshop:

To put it plainly, you got your 10,000 hours that Malcolm Gladwell talks about, the Beatles got, and the Apple and the Microsoft co-founders got. You get your 10,000 hours in your residency. If you're working 120 hours a week, in less than two and a half years, you've got 10,000 hours of face-to-face time with patients.

Dr. Frank Okosun:

Yeah, so don't get me wrong. I think there is a place for nurse practitioners and physician assistants in the healthcare system, but I don't think it's as a direct replacement for doctors. Medicine should be a team-based approach and like I said, these foreign docs are trained and ready to go. Most of them are already specialists in their respective countries where they are coming from, and I was talking to a colleague the other day in Canada, and Canada now are actually recognizing their post medical school training from their home countries.

Dr. Frank Okosun:

So if an anesthesiologist from Nigeria shows up in Canada, they allow them to practice family medicine with anesthesia privileges, the same thing for surgery and emergency room and all of that. And like I said, Ron, you can't say that the Canadian healthcare system is inferior to the U.S. medical system. Even Dr. Rand Paul, he had surgery a couple of years ago. He actually went to Canada to have the surgery done and paid cash for it, so the Canadian system, I think, is up there with the American healthcare system.

Ron Barshop:

I want to talk about burnout because we touched on it a minute ago. I have, what I do is I set up allergy clinics in primary care and so you become friends after 10 years at a clinic with some of the doctors. One of them was Nigerian and one was American born, were burned out. When you get to know them better, they'll tell you the real reason why they're burned out. The American said he had not had a raise in 25 years. He's been earning the exact same within a few thousand dollars for 20 years, and only the payoff of his building and the fact that it's going to be fully cash flowing in a couple of years is the only reason he keeps going.

Ron Barshop:

The Nigerian doctor has number of clinics where he lives, he's in a rural area, and he told me he had not paid himself a salary in 10 years, and he's 65. He's living off the rent of his buildings, which is considerable. It's not why you go to work every morning, you should get paid for a day's wages, and he sees more patients than all of his other doctors. So I don't think FMGs are immune from burnout, I think you guys probably have the same burnout, 65% ratio that the American docs have, don't you?

Dr. Frank Okosun:

Yes, I will say burnout is a relative term. Typically, FMG, during their training and their journey into the U.S. they have to face a lot of adversity. A lot of them, when they first get here, they have to do menial jobs to raise money for their exams and to take care of their families. They might be running away from countries of war and political and economical turmoil, so when they get to America, they really feel like they are in a land of milk and honey with a lot of opportunities. So they are willing to work the 80 hour work week or 90 hour work week and take multiple calls from different hospitals in order to survive, compared with an American graduate who might not have that kind of background. And foreign grads too, they tend to be a little bit more entrepreneurial compared with the American doctors who tend to go into now a more employed mode. Speaking of allergy programs, I actually had to set up an allergy program in my

clinic as additional source of revenue recently, because unfortunately, the insurance reimbursements are declining at a very, very fast rate.

Dr. Frank Okosun:

While the price of doing business is going up, rent has gone up, mortgages have gone up, wages have gone up, but the reimbursements are actually going in the opposite direction. So doctors feel like we have to see more patients in order to keep a roof over our head, or we have to add ancillary services to improve our revenue streams in order to stay profitable. So it's a very, very difficult process that takes a lot of toll on our psychological health, our mental health, and the work-life balance, so it's not uncommon. I know a couple of anesthesiologists and orthopedic doctors who have gone into research or academia or working for insurance companies or pharmaceutical companies, where they don't have to deal with the bureaucracy and documentation aspects of healthcare. A lot of people are also going into administration, to being chief medical officers and CEOs of hospitals.

Ron Barshop:

So to round out this discussion, the most elegant solution for solving our shortage of doctors, if telehealth has already kind of got its boost it was going to get because of COVID, is going to have to be FMGs or international medical graduates. Foreign medical graduates. So what we're talking about here, for every 10,000 that we can get slotted in or get onboarded quickly, that's 25 million patients that are in a panel that could be served. That is mostly internal medicine and a lot of pediatrics, so it's mostly primary care we're talking about here.

Ron Barshop:

We know we have 15,000 PD, I don't know what the internal medicine number is, but it's a little bit less than that, but it's safe to say there's somewhere between 20 and 30,000 or more FMGs that can't get slotted and therefore can't practice in America quite yet. And with only 5,000 IMG slots available in our aged 1994 slotting machinery, there's no way we're going to get through all that. They've already waited five or seven years. They're going to have to wait another maybe, five to seven years. It's stupid. So the simple solution is for states to do what they need to do to get their FMGs on board with this three-year apprenticeship, and I think that's going to be the answer, without nurses, without the telehealth, as another answer.

Dr. Frank Okosun:

Like you said, you hit the nail on the head. The process of having residents in this system, it's a moneymaker. I don't know if you followed the news a couple of months ago, there was a program, a hospital in Philadelphia that had to be closed due to some logistics situations, and the residency programs in that hospital, they were actually put up for auction. I don't know if you were aware or heard about that. And those programs, those residency slots, they were going for millions of dollars.

Dr. Frank Okosun:

So the GME actually had to step in and say, "Hey, you can't just do a short scale auction sale and sell these slots." Because like you said, millions of dollars in federal funding and grants and GME funds that all these hospitals get. So those residents that were still in training, they had to

find other residency programs for them to go to complete their training, but those residency programs and those positions were actually sold, were sold for a lot of money. So I wanted you to look that up. It was in Philadelphia. I mean, I know the hospital, but I don't want to mention it for obvious reasons.

Ron Barshop:

Well, that's okay. If you take $1,000,000, which is what they bill these folks out at, and they're paying them 60 grand, that's pretty good markup, right? And they're not even paying them 60 because it's federally subsidized and they're paying them zero.

Dr. Frank Okosun:

Yes, yes.

Ron Barshop:

They might be paying FICA and FUTA, but a lot of these non-profits don't have to pay a lot of taxes. The bottom line is it's an extremely valuable position. So yeah, it's an elegant solution to expand slots, but that's beyond the thinking of hospital administrators a lot of times, but look, Frank, this has been a great, well-rounded discussion on this subject and I'm really glad we had you on the show. And hopefully, in the next five years when we sort of have to do something about this, we will have come to our senses in America and no more Uber drivers as doctors. That's our goal here.

Dr. Frank Okosun:

Yes, I totally agree.

Ron Barshop:

Yeah. Well, thanks again, and we'll get you on the show again soon to catch up, okay?

Dr. Frank Okosun:

Thank you so much, Ron. You, have a great weekend.

Ron Barshop:

Thanks, Frank. You too.

Ron Barshop:
Thank you for listening. You want to shake things up. There's two things you can do for us. One go to primarycarecures.com for show notes and links to our guests. And number two, help us spotlight what's working in primary care by listening on iTunes or wherever you get your podcasts and subscribing. And leave us a review. It helps our megaphone more than you know. Until next episode.