
Correspondence

RESPONSE TO “ALLERGIST REPORT: AMERICA FACES AN ALLERGY/ASTHMA CRISIS”

To the Editor:

It was with bittersweet amusement that I read the “Allergist Report: America Faces an Allergy/Asthma Crisis,” dated April 2007.¹ The report makes a number of unsubstantiated statements in an attempt to persuade that a critical shortage of practicing allergists is eminent. The rationale for training more allergists includes an increase in allergic disease and asthma and a call to increase the number of allergy training programs. Mention is made of previous failed attempts to redistribute allergists to areas of greater geographic demand. I am unaware of any such attempts to redistribute allergists. I am troubled by the committee’s obliviousness to real-life factors, such as primary care physicians’ reluctance to refer to specialists, otolaryngologists, pulmonologists, primary care physicians, chiropractors, and alternative medicine practitioners practicing allergy and continued cuts in reimbursement by Medicare, Medicaid, and private insurers. The community I practice in has a population of 275,000 and 16 practicing allergists. It is estimated that a population of 100,000 to 120,000 is required to support a single allergist. Other areas of the county may have a greater need for allergy specialists, but it should not be forgotten that most patients with allergic disease and asthma never see an allergist. Also, training more allergists will do nothing to encourage the new allergists to seek out underserved areas, typically rural and undesirable, to practice in. I believe it is shortsighted and irresponsible to encourage more training program slots in a specialty that is underused. It would make more sense to lobby to limit the practice of allergy to board-certified/board-eligible allergists and encourage allergists to retire at a reasonable age. Otherwise, the future will be bleak indeed for the legion of allergists this report proposes to raise.

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REFERENCE

1. *Allergist Report: America Faces an Allergy/Asthma Crisis*. Arlington Heights, IL: American College of Allergy, Asthma & Immunology; 2007.

The above correspondence was referred to the original authors who provided the following response:

The letter by Dr Mann points out many differences in distribution, perspective, and perception regarding the US physi-

cian and allergy workforce and the realities of caring for patients with allergic disorders in this country.

As suggested by Dr Mann, there are some areas of this country that have enough or more than enough allergists to meet the allergy care demands of those patients who have access to that care and there are localities and some areas that produce more than sufficient numbers of allergists for their surrounding areas. Projections of medical workforce needs have some inherent inaccuracies, but several clear trends support a need for more training positions and programs: the number of allergists being produced is less than it was in the past, the population of the country has grown and is growing more rapidly than projected in the past, allergic disease is more common now, the allergist physician population is aging, physicians in general are working shorter careers, and lifestyle considerations, including fewer work hours, are consistently more important factors for many newly trained physicians than in the past. Thus, the workforce issues that do not affect all areas, yet really become manifest in the future more broadly than now, and the lag before we could see any substantial increase in allergist production will be at least 5 to 7 years away and likely more.

It is well established that many people with allergic diseases either are not treated or are treated by physicians other than allergists. Some are managed quite well by other physicians. Nevertheless, we believe that significantly affected allergic individuals are best treated by allergists and that our population would be better served by having more specialists, not fewer. Neither we nor anyone else can predict whether access to allergists will be easier or more restricted in the future, and this will have a huge effect on need for specialists in our field. Many patients who would benefit from an allergist’s care cannot access that care now.

The maldistribution of allergists is not unique to our specialty and there are no easy solutions to the problem. Simple efforts, such as informing fellows and allergists of the problem, have not addressed the need. We think the growth of programs, especially those in undersupplied areas, is more important to the country as a whole than closure of programs in oversupplied areas. In some places, the absence of allergists is so acute that ear, nose, and throat physicians are taking weekend courses to learn how to treat asthma.

Restraint of trade issues, access to care, and individual freedoms are all considerations that limit stances on requiring specific diseases to be treated by a particular specialty. We contend that decisions on when to retire are best left to individual physicians and their families.

We agree that there is a compelling need to raise awareness about how allergists can help patients with allergies. To

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further that purpose, the American College of Allergy, Asthma, and Immunology is embarking on a major public relations effort over the next several years, which we hope will bring this message to potential patients and to other physicians.

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