

# 1991 Presidential address

## The most important issue facing the specialty of allergy and immunology today

Fellows, members, and guests of the American Academy of Allergy and Immunology, the most important issue facing the specialty of AAAI today is *support for the allergy and immunology academic centers and their training programs that supply the allergists and immunologists of tomorrow!*

### LESSONS FROM THE PAST

In 1976, an AAAI specialty Manpower Committee, headed by Phil Norman, MD, reported that we had a total that year of 2677 allergy and immunology specialists or one specialist per 80,000 people, given a U.S. population of 215 million.<sup>1</sup>

This committee estimated that the optimal ratio of allergists and immunologists to the general population was 1:50,000 to meet the needs of the country. The breakdown of our manpower needs was stated as 4250 practitioners and 1400 academic physicians, involved as teachers, researchers, and clinical immunologists. This finding totals 5650. Given a physician supply of 2677, this left a deficit or an undersupply that year of 2973 physicians. According to Dr. Norman's committee in 1976, we were supplying only 47% of the allergy and immunology specialists needed in the United States.

During Dr. Oscar L. Frick's AAAI Presidential Address,<sup>2</sup> he stated that the average number of allergy and immunology fellow graduates during the decade of the 1970s was 126. He also estimated that the attrition rate from the specialty manpower pool, that is, the number of physicians who retired from active practice, was 80 per year. Thus, in the 70s we could count on a net addition to our physician manpower pool of only 46 new allergy and immunology specialists per year. Given an almost certain change in our U.S. population, Dr. Frick stated that it would take "75 years" to meet the allergy and immunology specialty manpower deficit!

#### Abbreviations used

|         |                                                        |
|---------|--------------------------------------------------------|
| AAAI:   | American Academy of Allergy and Immunology             |
| GMENAC: | Graduate Medical Education National Advisory Committee |
| AMA:    | American Medical Association                           |
| NIH:    | National Institutes of Health                          |
| NIAID:  | National Institute of Allergy and Infectious Diseases  |

### 1990 ALLERGY AND IMMUNOLOGY PHYSICIAN NEEDS AND SUPPLY

In 1980, the U.S. Government publicized the report of the GMENAC.<sup>3</sup> This study projected that the need for practicing allergists and immunologists in the year 1990 would be 2950. The study also estimated that the supply of specialists that year would be 3950 or "1000 excess allergists and immunologists."

The GMENAC report was based on a unique study of medical manpower needs based on what it would take to manage specific diseases. All specialties in medicine were included in these estimates. Unfortunately, though a number of adjustments were made concerning the 1990 final estimates for needs in our specialty and the academic/research/clinical immunology needs in the 1980, the GMENAC study was almost completely ignored.

In 1990, our specialty was offered an important opportunity. The Council of Graduate Medical Education had been established by the U.S. Congress to determine the present and future needs for medical and surgical physicians, by specialty, for the years 1990, 2000, and 2010.<sup>4</sup> These new estimates were to be made on a disease-needs based estimate as an update of the 1980 GMENAC study.

However, government funds were only available to do estimates for the five primary specialties, such as Internal Medicine and Pediatrics. All other specialties were invited to participate in, and fund on their own, a parallel GMENAC update of their manpower needs and supply by ABT Associates, Inc., Bethesda, Md., the U.S. Government contractor. The AAAI and the

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TABLE I. Allergy and immunology physicians

|                             | Year: 1990 | 2000           | 2010           |
|-----------------------------|------------|----------------|----------------|
| Need (ABT Associates)       | 6214*      | 6561           | 6839§          |
| Supply (AMA/ABT Associates) | 3860†      | 4599           | 5093           |
|                             |            | 739<br>(74/yr) | 494<br>(50/yr) |
| Deficit                     | 2354 (38%) | 1962 (30%)     | 1746 (26%)     |
| Supply (AAAI)               | 4312‡      | 4692           | 5002           |
|                             |            | 380<br>(38/yr) | 310<br>(31/yr) |
| Deficit                     | 1881 (30%) | 1848 (28%)     | 1816 (27%)     |

Ratio of general population of 250 million:

\*1:40,000.

†1:67,000

‡1:60,000

§1:40,000.

TABLE II. AAAI National Manpower Survey

| Practice character                         | Year (%) |      |
|--------------------------------------------|----------|------|
|                                            | 1987     | 1990 |
| Too busy                                   | 24       | 28   |
| Accept all patients, work<br>desired hours | 53       | 53   |
| Not busy                                   | 23       | 19   |

American College of Allergy and Immunology decided to jointly participate and fund a parallel study by ABT Associates, Inc., and we were one of the few specialties to do so.

According to the 1990 study of ABT Associates, the 1990 needs for Allergy and Immunology is 6214 physicians (5026 practitioners and 1188 in academic medicine as teachers, researchers, and clinical immunologists) (Table I). Our specialty manpower need is projected to increase by 6% to 6561 by the year 2000 and another 4% by the year 2010 to 6839 physicians (Table I; Fig. 1). This equates to one allergist and immunologist per 40,000 population, given a population base of approximately 250 million.

With AMA statistics, ABT Associates estimates that our present supply of allergy and immunology specialists at 3860 (1:67,000 general population). The Manpower Committee of the AAAI estimates our physician supply slightly higher, at 4312 (1:60,000 general population). Either way, there is a deficit of allergy and immunology specialists at the present time of approximately 2000 physicians. In 1990, then, the

TABLE III. AAAI National Manpower Survey

| New patient visit | Year (%) |      |
|-------------------|----------|------|
|                   | 1987     | 1990 |
| 0-2 days          | 42       | 42   |
| 1 week            | 29       | 27   |
| 2 weeks           | 18       | 12   |
| 3-4 weeks         | 7        | 12   |
| >5 weeks          | 4        | 7    |
| Total             | 100      | 100  |

study by ABT Associates estimates that we are only supplying 62% of the specialty physicians needed for Allergy and Immunology today. Furthermore, the study by ABT Associates projected that as the physician need in our specialty increases during the next 20 years, the physician supply will impact little on the deficit. By the year 2010, we will still be under-supplied on our allergy and immunology specialty manpower by 27% (Fig. 1).

**Supportive evidence for need-based estimates of ABT Associates**

Is there any supportive evidence for the estimates that ABT Associates has made concerning the need for allergists and immunologists?

The AAAI began a program of regular assessments of our manpower needs in 1987. Our survey was recently repeated in 1990.<sup>5</sup> One question that was asked of our practitioners related to "how busy are they" (Table II). Twenty-four percent in 1987 and 28%

TABLE IV. AAAI National Manpower Survey

| Response | Plan to add a partner within 1 year? |      |
|----------|--------------------------------------|------|
|          | Year (%)                             |      |
|          | 1987                                 | 1990 |
| Yes      | 15                                   | 22   |
| No       | 77                                   | 78   |
| NA       | 8                                    | —    |
| Total    | 100                                  | 100  |

NA, No answer.  
 $22\% \times 3860 \div 3 = 283$  potential "jobs."

TABLE V. Allergy and immunology career opportunities<sup>6</sup>

|            | Year  |      |       |
|------------|-------|------|-------|
|            | 1985  | 1989 | 1990  |
| Jobs       | 316   | 265  | 259   |
| Graduates  | 66    | 55   | 48    |
| Mean       | 4.7   | 4.8  | 5.4   |
| Medium No. | 4(12) | 4(9) | 3(10) |
| Range      | 1-20  | 1-20 | 1-20  |

Anderson JA. Unpublished data.

in 1990 reported that they were either observing too many patients or working too many hours.

Although 42% of allergy and immunology physicians stated that they could observe a new patient within a few days, in both our 1987 and 1990 survey, there was a tendency for a longer backlog for a new patient-visit appointment in 1990 than in 1987. In 1990, 12% of physicians reported that their new patients had to wait 3 to 4 weeks and 7% reported a 5 week wait (Table III).

When allergy and immunology physicians were asked if they were planning on adding a partner within the following year, 15% in 1987 and 22% in 1990 responded to this question with a "Yes." A conservative estimate of the effect of this question would be the availability of 283 potential "jobs." (This finding is based on a supply of 3860 physicians and an average of three physicians per allergy and immunology partnership [Table IV].)

Another way to consider specialty needs is to assess the demand for jobs among our new allergy and immunology fellow graduates. For a number of years, I have been assessing these demands<sup>6</sup> (Table V). Career opportunities appear to be readily available for our graduates, regardless of the type of career that they

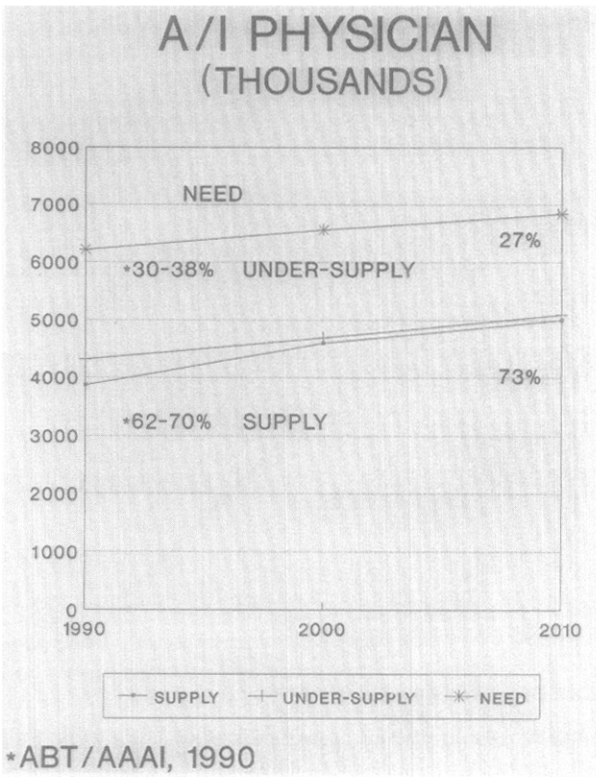


FIG. 1. Comparisons of the allergy and immunology (A/I) physician needs, undersupply, and supply, in the United States for the years 1990, 2000, and 2010. Numbers are indicated in thousands of physicians. Supply numbers are based either on a study by ABT Associates, 1990<sup>4</sup> (62% of need in 1990) or AAAI estimates, 1990 (70% of need in 1990). AAAI supply projections are based on an estimate of 125 graduates per year added to the pool less the number needed to account for a 2% attrition rate (see text).

pursue. In 1985, 1989, and 1990,<sup>6\*</sup> each graduate interviewed for an average of five jobs, and 60% of these opportunities were rated as good by our allergy and immunology fellow graduates.

### Supportive evidence for physician supply estimates of ABT Associates

What is the evidence for the continued physician supply problem in our specialty?

In the decade of the 1970s, Dr. Frick determined that we were graduating an average of 126 allergists and immunologists per year. In the decade of the 1980s, these numbers remained approximately constant at an average of 125 graduates per year. Of these graduates, Dr. Frick estimated in 1978 that 24% went into "academic practice."<sup>2</sup> My own estimates, based on a survey of allergy and immunology training pro-

\*Anderson JA. Career opportunities for allergy fellowship graduates in 1989 and 1990 (personal communication).

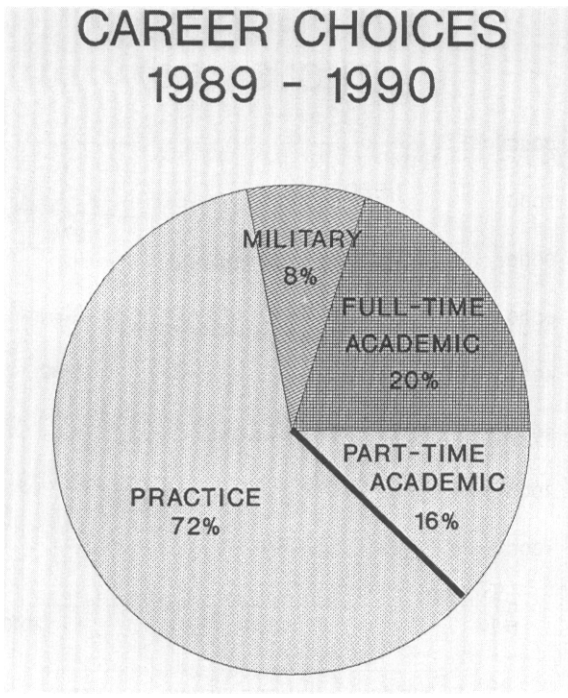


**FIG. 2.** Distribution of career choices of 115 allergy and immunology fellows graduating either in 1989 or 1990 according to surveys of graduates. Choices include military, full-time academic (careers), and practice (either solo, group, or allergy and immunology specialty partnership). Sixteen percent of those choosing practice claim to participate part time in academic careers.

grams in 1984 and fellow graduates in 1985, 1989, and 1990, were that 22%, 21%, and now 20%, respectively, were going into full-time academic careers<sup>6\*</sup> (Fig. 2). In 1989 and 1990, another 16% were going to devote some of their time as part-time academicians, but were going to obtain most of their income from private practice.

Dr. Frick, in his Presidential Address in 1978, estimated that we had an attrition rate of 80 physicians that year. The AMA estimates that the attrition rate of all physicians in any specialty is 2% per year.<sup>4</sup>

Approximately 75 of our AAAI members each year advance to emeritus status, and we hold a memorial for approximately 20 of our members per year. Given the fact that 3% to 5% of our members have attained an age of 70 years or older, the AMA attrition rate from active practice of 2% for our specialty appears reasonable.

If our allergy and immunology training programs remain stable with approximately 125 graduates per

\*Anderson JA. Career opportunities for allergy fellowship graduates in 1989 and 1990 (personal communication).

**TABLE VI.** Allergy in university departments of internal medicine

| No. full-time staff | Year              |         |
|---------------------|-------------------|---------|
|                     | 1980 <sup>a</sup> | 1990*   |
| Zero                | 59(47%)           | 50(43%) |
| One                 | 32                | 23      |
| Two or more         | 33                | 43      |
| Total staff         | 65                | 66      |
| Total department    | 124               | 116     |

\*Anderson JA. Unpublished data.

**TABLE VII.** Clinical immunology in university departments of internal medicine

| No. full-time staff | Year              |         |
|---------------------|-------------------|---------|
|                     | 1980 <sup>a</sup> | 1990*   |
| Zero                | 38(31%)           | 45(45%) |
| One                 | 30                | 16      |
| Two or more         | 56                | 40      |
| Total staff         | 86                | 56      |
| Total department    | 124               | 101     |

\*Anderson JA. Unpublished data.

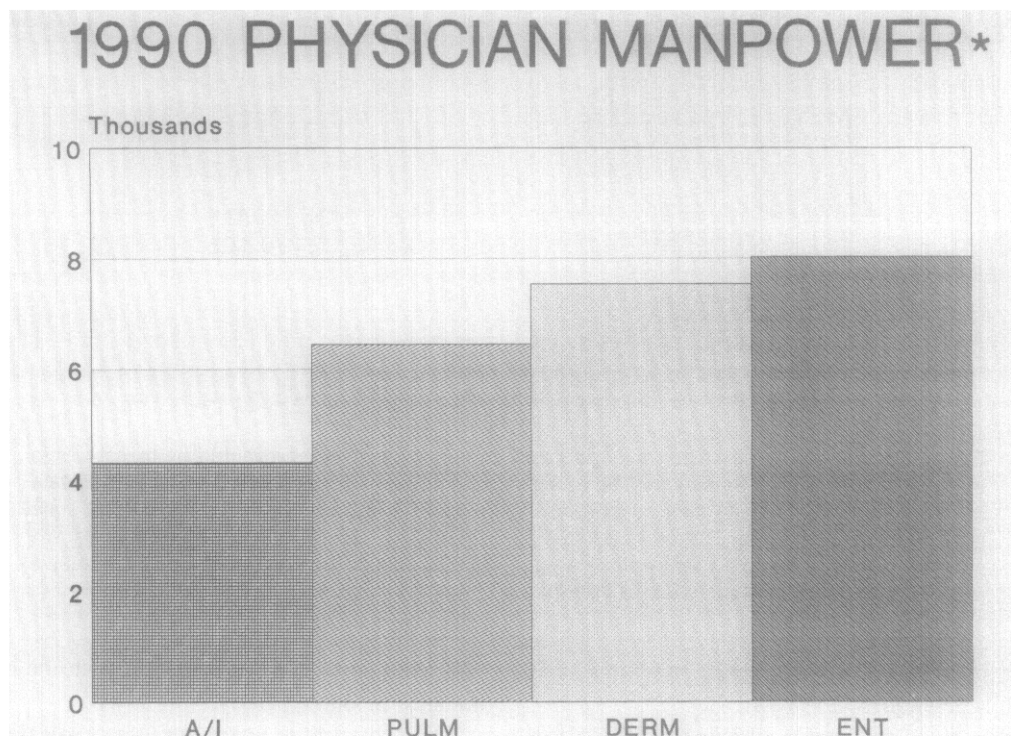
year, during the next 10 years, we will only add 38 per year to the physician supply between 1990 and the year 2000, and only 31 per year between the years of 2000 and 2010 (Table I, Supply).

Our specialty is not growing like our competitive specialties. According to AMA data, between 1975 and 1985, when our specialty was experiencing little growth, our nearest competitors, such as pulmonary medicine, dermatology, and otolaryngology, grew 118%, 41%, and 26%, respectively. In 1990, Allergy and Immunology still rank well behind the specialties of Pulmonary Medicine, Dermatology, and Otolaryngology in physician supply (Fig. 3). Since our specialty number increases have not kept pace with increases of other specialties, it is small wonder that we are not competitive!

**Academic allergy and immunology needs and supply**

What evidence is there concerning needs and supply in academic Allergy and Immunology?

Mullally et al.,<sup>8</sup> at the NIAID in 1980, surveyed all the U.S. university chairpersons in Departments of Internal Medicine and Pediatrics as to members of their staff that they had in Allergy and in Clinical Immunology. In 1990, I repeated this survey, asking



**\*PHYSICIAN CHARACTER, DIST.USA, AMA 1986 (ADJUSTED)**

**FIG. 3.** Approximate manpower of specialty physicians in 1990 involving the specialties of allergy and immunology (A/I), pulmonary medicine (Pulm), dermatology (Derm) and otolaryngology (ENT). Numbers for pulmonary, dermatology, and otolaryngology are adjusted based on average yearly growth 1986 to 1990.<sup>7</sup> Numbers for allergy and immunology reflect AAAI estimates.

the same questions of university department chairpersons.\*

In 1980, 47% of university Departments of Internal Medicine had no full-time academic staff in Allergy (Table VI). In 1990, still 43% of university chairmen of Internal Medicine reported that they had no full-time allergists in their department. (Forty-eight percent of chairmen of Pediatrics in 1980 and 38% in 1990 reported that they also had no full-time allergists in their department.)

Similarly, of the chairpersons of Internal Medicine surveyed, 31% in 1980 and 45% in 1990 claimed to have no immunologist on their staff (Table VII). (Forty-four percent of the chairpersons of Pediatrics in 1980 and 20% in 1990 reported that they had no full-time clinical immunologists in their department.)<sup>8\*</sup>

Thus, an average of 40% of the Departments of

Internal Medicine and Pediatrics today have no full-time allergist or clinical immunologist on their staff. There has been little change in this average in the past 10 years. (In 1980, average of 42% of Departments of Internal Medicine and Pediatrics had no allergy or immunology specialists on their staff.)

**BASIC PROBLEMS IN ACADEMIC ALLERGY AND IMMUNOLOGY CENTERS AND THEIR TRAINING PROGRAMS**

The key to addressing the manpower issues in Allergy and Immunology rests in solving the problems of our academic centers and their training programs that supply our future allergists and immunologists.

In 1978, Norman et al.<sup>1</sup> and Frick<sup>2</sup> realized this, and Dr. Frick, in his Presidential Address, focused on direct financial support of the fellow in training. The basic problems that are plaguing our academic centers, however, are more than just direct support to the salaries of fellows.

In simple terms, the basic problems of our academic centers are issues of "halves."

\*Anderson JA. Academic manpower in allergy and clinical immunology—needs and supply in 1990 (personal communication).

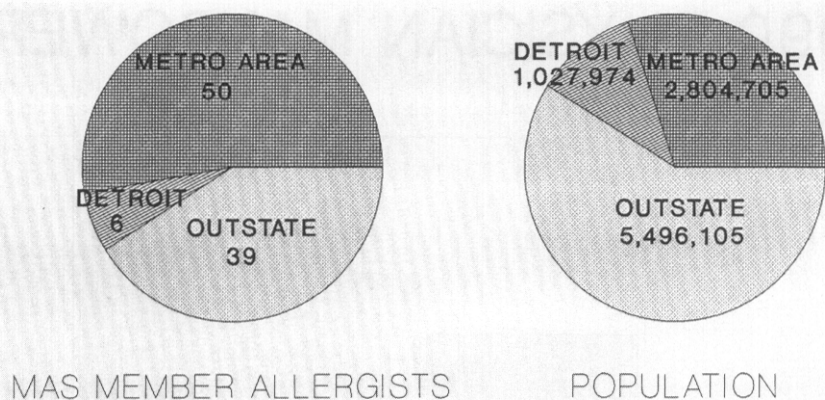


**FIG. 4.** Comparison of practicing allergists and immunologists as represented by membership in the Michigan Allergy Society in 1990 to the general population (U.S. 1990 census). Total state of Michigan population in 1990, 9,328,784. Allergists and immunologists (95) per total state population, 1/98,198; per Detroit population, 1/171,329; per Detroit metropolitan suburbs, excluding the city of Detroit (metropolitan area), 1/56,094; rest of the state of Michigan exclusive of Detroit and suburbs (outstate), 1/140,926.

1. Approximately one half of training programs have few full-time staff.
2. Recently, there has been a significant, 50%, drop in NIH funds awarded to allergy and immunology staff in our academic centers.
3. Only 50% of our fellows in training have "secure" institutional funding (and that may be in jeopardy).
4. Approximately one half (40%) of the medical schools do not have Allergy or Immunology divisions.

#### Academic allergy and immunology full-time staff

According to the Chairman of the Residency Review Committee for Allergy and Immunology, during the 1980s, we reached a high of 87 training programs (1985, 1986, and 1989) (Reisman RE. Personal communication). In 1991, however, we now have a low number of 81 approved programs. In approximately 90% of cases, the training program director is full-time. However, in a substantial number of training programs, only the training program director or the director plus one other staff member is full-time.

The implications of this problem are threefold: *First*, with only part-time staff or few full-time staff, it appears unlikely that these staff would have much time to be personally involved in studies involving new or basic technology. Although they might have some time for descriptive studies, they would have little time for mechanistic studies, the type that NIH are more likely to fund.

*Second*, under the circumstances of deficit staff, it is hard to imagine that the graduates of these programs

will learn, firsthand, how to deal with the new technologies of our specialty.

*Third*, the future upgrading of our specialty is dependent, not only on a steady supply of new graduates from our training program, but also new "partners" who have more skills than those graduates of the past. The practical aspects of the new technology of our specialty must be "passed on" by these graduates to us, the practitioners.

At the 1991 AAAI retreat for allergy and immunology training program directors, a resolution was passed stating that every allergy and immunology training program should have a minimum of two full-time staff. To fulfill this mandate, it would require many additional academic allergists and immunologists.

#### NIH research support

NIH research support is harder to obtain, regardless of your specialty! However, the number of academic allergists and immunologists receiving direct NIH support has decreased almost 50% from its former level in recent years. This is an alarming drop compared to the situation in other specialties, according to NIAID (Prográís L. Personal communication).

Although the exact reasons for this decrease in funding have not been identified at this time, one reason may be the fact that, as monies get tight and the competition for limited research funding increases, our specialty lacks the depth in resources to adequately compete.

The results of this NIH research funding problem are three fold: *First*, without long-term NIH governmental funds, our allergy and immunology academic

centers will find it hard to compete at their own institution. Furthermore, it is a "catch-22" situation. These centers will not be able to acquire the depth of resources to compete for future outside institutional research funds (such as additional NIH funds).

*Second*, without secure long-term outside research funding for our allergy and immunology academic centers, our specialty runs the risk of not being involved in the allergic, asthmatic, and immunologic advances of the future, the "new technologies."

*Third*, the allergy and immunology practitioner also runs a risk, that of not being educated by our own specialists concerning the new technology of the future!

**Allergy and immunology fellowship funding**

Dr. Frick recognized in 1978 that the funding of our fellows in training was not secure. Only 50% of our training programs receive some institutional support for their allergy and immunology trainees.<sup>2</sup> A recent poll of the Allergy and Immunology Training Program directors demonstrated that this percentage, in 1990, has not changed.

Furthermore, under newly adopted Medicare rules, the government is only reimbursing institutions for allergy and immunology fellows (residents) for one half their cost at the second (or third) training-year level. The result of this recent change is that the institutions who are funding our programs must now pick up the difference, if these training programs continue. Thus, each institution funding advance trainees, such as our specialists, are reevaluating the overall composition of training programs in their centers. Unfortunately, also, these same institutions are taking a harder look at support for protected time of the fellow in training to be involved in research in favor of the fellow being involved more in patient care, which is cost reimbursed to the institution.

**Allergy and immunology divisions in universities**

As stated before, only an average of 60% of our medical schools have any full-time allergist or clinical immunologist on their staff. The result of this problem is, that as a whole, our specialty of allergy and immunology cannot expect to compete for those resources that are available, locally. If our Allergy and Immunology centers are not in almost all medical schools, we cannot expect to compete, nationally, as a group! Based on our surveys, to supply one or two allergists or immunologists to each university needing these specialists will take 7 to 13 years (with *no* at-

**TABLE VIII. 1990 academic manpower additional needs**

| No. specialist   | IM  | Peds | Total | Yr* |
|------------------|-----|------|-------|-----|
| One allergist    | 50  | 42   | 92    | 4   |
| Two allergist    | 93  | 83   | 176   | 7   |
| One cl immunol   | 45  | 31   | 76    | 3   |
| Two cl immunol   | 85  | 67   | 152   | 6   |
| Two total staff  | 95  | 73   | 168   | 7   |
| Four total staff | 178 | 150  | 328   | 13  |

*IM*, Immunologist; *peds*, pediatricians; *cl immunol*, clinical immunologist.

\*Number of years necessary to supply new academic graduates based on 125 graduates per year, 20% or 25% of which go into academics (with no attrition).

trition)<sup>6, 8\*</sup> (Table VIII). At the present rate, we can expect little change in this situation, unless we do something!

**AAAI Educational Endowment Trust Fund**

The issue facing us now is how can we influence these adverse ongoing manpower trends that I have presented to you? How can we solve the problems facing our academic centers and our training programs?

The answer lies, in my opinion, largely in having the finances or the capital to "give a boost" or to "jump-start" our academic/research programs! In 1988, the AAAI Educational Endowment Trust Fund was established through the efforts of Jordan Fink and Phil Lieberman. The purpose of this fund is to promote academics and research in allergy and immunology.

I believe that there are three reasons why we should support this trust fund:

1. The supply of new allergists and immunologists, our future partners, is dependent on the existence of many allergy and immunology centers, I hope in most universities, each staffed by several academic allergists and immunologists.
2. The future technology to be used in our practices must be developed by the research today in our allergy and immunology academic centers.
3. The future continuing education, which each allergy and immunology practitioner needs, can only be guaranteed if our academic centers are involved

\*Anderson JA. Career opportunities for allergy fellowship graduates in 1989 and 1990, and academic manpower in allergy and clinical immunology—needs and supply in 1990 (personal communications).

in developing the new technologies of our specialty.

### 10 MILLION DOLLAR CAMPAIGN

The original fund goal was to accumulate 1 million dollars in capital and to use the investment proceeds for educational and research purposes. Thus far, we have only accumulated \$60,000 toward that goal! At this rate, we will achieve only limited success.

It is for this reason, today, that I am launching a new, 3-year, 10 million dollar campaign to support our newly named AAAI Education and Research Trust Fund. For this campaign, I need your personal involvement!

### Why 10 million dollars?

Our original goal of 1 million dollars is not enough. One million dollars invested at a conservative rate of 8% will yield \$80,000 in interest on a yearly basis. To keep up "buying power" of our capital investment, we must keep up with inflation (6% in 1990). The fund corpus must be continually enlarged. If one half of the \$80,000 of interest earned was reinvested for this purpose, it leaves us with \$40,000 in fund proceeds for the AAAI to use toward educational and research promotion.

Forty thousand dollars per year for this purpose will have *little* impact on the manpower issues or the problems facing our academic centers/training programs! Thus, *any* multiple of 1 million dollars in our fund will result in more monies on a yearly basis so that we can work toward solving our problems. I sincerely hope we can reach a goal of 10 million dollars in 3 years!

### AAAI education and research endowment trust fund use

I, personally, believe that the proceeds of our endowment fund should be primarily used for three purposes:

1. To support research (and protected time to be involved in research activities) during the first 8 years of a new academic allergist and immunologist's career; 20% of our present graduates or 25 individual fellows are embarking on full-time academic careers. This is a reasonable number, if these individuals were supported for their research involvement until such time that their efforts would be competitive for outside (government) funds. The NIAID estimates that it takes 8 years to be competitive (Proga L. Personal communication). Perhaps, if the AAAI could help in this effort, the academic career would be more attractive and the
2. To supplement the financial support to institutions sponsoring allergy and immunology training programs for the second (and possibly third) year of training.  
There is no reason in my mind that an allergy and immunology trainee could not qualify for residency support at any institution, at least for that part of his or her program that is involved in patient care activities.  
However, I recognize that the institution providing such support is now under new Medicare reimbursement rules, which makes the institutions liable for one half of the second and subsequent year of fellowship (residency)-training support. Should the AAAI help in this effort, they may encourage institutions to take on the bulk of the support and thus make our training fellowship finances more secure.
3. To offer 3-year, matching grants to medical schools on a competitive basis to stimulate the establishment of new allergy and immunology divisions. Strong medical school allergy and immunology divisions will result in more training programs and predictably more graduates to our manpower pool.  
This idea, developed by John Salvaggio, MD, has been adopted as a long-term goal of the AAAI Executive Committee. It has not been possible, however, to proceed with this program, thus far, because of lack of capital.

### CONTRIBUTORS TO THE AAAI EDUCATION AND RESEARCH TRUST FUND

The needs are there. The problems associated with supplying these needs have been identified. A plan has been formulated to solve the problems. Now the next question is, who is going to contribute to the fund? **How about you and me?**

The original idea, when Drs. Fink and Lieberman launched the Educational Endowment Trust Fund, was that 50% of the 1 million dollars would come from the AAAI membership and 50% from industry. Drs. Jordan Fink, Irv Tabachnick, and Rick Iber of the Academy staff, and all subsequent AAAI presidents, including Phil Lieberman, Allen Kaplan, and myself, have been actively soliciting our pharmaceutical industry colleagues for support.

Only \$60,000 has been contributed to the fund to date. Most of this support has come directly or indirectly from industry sources. Significant additional industry support has been pledged, such as two grants of \$100,000 each from Muro Pharmaceuticals and

Schering Corp. have been announced. Much of the costs for the Asthma and Allergy Foundation of America-AAAI Educational Research yearly benefit at the annual AAAI meeting have been underwritten by industry.

What I believe has been lacking so far in this whole process is a commitment by all of us, the practicing allergists and immunologists, to contribute in a major way to help create a significant endowment. After, all it is *our* future that we are talking about! How good our future will be, in my opinion, depends directly on how much each of us is willing to contribute!

Many of you will say, "But these are bad times!" I will answer, "There may never be better times." Or you may say, "Things will work out by themselves; they don't need our help." And I will answer, "Things are not working out and they are projected to get worse!"

Others may say, "It's not my problem; let the government or the pharmaceutical industry do it." I say, "It is our problem, and the government and industry are helping, but that is not enough!" Finally, some of you may say, "We don't need any more allergists in our area; we don't need further competition." I say, "You may be right, but we need more allergists and immunologists, countrywide, and the laws of supply and demand should settle physician-supply distribution issues."

There is evidence that this latter issue is being solved. There is a variation, nationwide, on the distribution of allergists and immunologists between the suburbs, the city, the rest of the state, and between various areas of the country. (For example, there are more allergists and immunologists in practice in the suburbs, and more in the East and in the Midwest, and less in the South.<sup>1-6</sup>)

As an example, in 1990, in the state of Michigan, 50 allergists and immunologists who are members of the Michigan Allergy Society were in practice in the Detroit suburbs, serving a population of approximately 2,800,000 people, giving a ratio of one allergy and immunology specialist per 56,094 population, very close to the optimal ratio of 1:40,000 population as recommended by the projections of the ABT Associates<sup>4</sup> (Fig. 4). In contrast only six allergy and immunology specialists in Michigan were serving Detroit (1:171,329 population), and 39 specialists were serving the rest of the approximately 5.5 million population (1:140,926 population).

The laws of supply and demand, however, would dictate that as job opportunities decrease in one area, individuals will seek career opportunities in other areas. In our survey of allergy and immunology fellowship graduates from 1983 to 1985, 41% went into

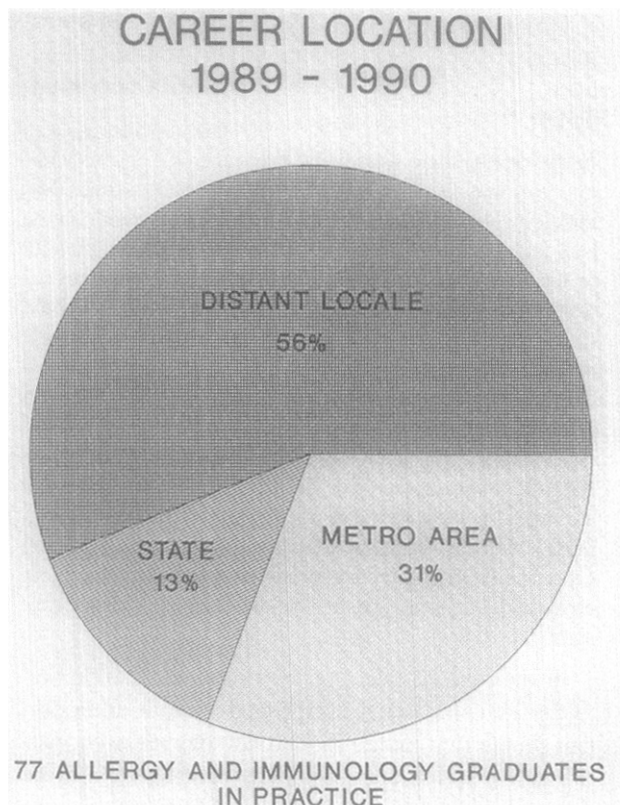


**FIG. 5.** Distribution of practice career location choices (solo, group practice, or allergy and immunology specialty partnership) of 77 graduates of allergy and immunology fellowship programs in the years 1989 or 1990. *Metropolitan area* refers to the same city or suburb in which the fellow graduate trained; *state* refers to the same state in which she or he trained; *distant locale* refers to all other areas of the United States (or world).

practice in the same metropolitan area in which they trained, and 18% went to other areas of the state.<sup>6</sup> The remaining 41% went to other areas of the country. Our recent surveys, however, reveal a trend for less graduates to settle in the metropolitan area in which they trained and more of a trend to travel out of state for career opportunities (Fig. 5). Thirty-one percent chose the metropolitan area, 18% the same state in which they trained, and 56% went out of state for a career opportunity.

#### **What are other specialties doing in order to support academics and research?**

In 1962, Thomas Fitzpatrick, MD, started the Dermatology Foundation with a single contribution of \$50,000 from a practicing Chicago dermatologist, Clark W. Finnerund. This is a foundation made up of dermatologists committed to supporting academic and research dermatology.

Here are some excerpts from Dr. Fitzpatrick's writings concerning the founding of this foundation entitled, "Needs of the specialty lead to a new foundation."<sup>9</sup>

In the 1960's, there were many major medical centers without full-time Dermatologists. The lack of full-time Dermatology Departments inhibited progress in research on the skin and affected the quality of Dermatology being taught to medical students, house officers, and post-graduate education for non-Dermatologists. AND "Our specialty could (if it tried) develop a presence in the medical schools in patient care, in teaching, and especially in fundamental and clinical research at a level of excellence commensurate with other medical specialties such as Cardiology, Endocrinology, Metabolism, Neurology, and Nephrology." AND FINALLY "High standards of Dermatology practice arise and are maintained by our academic department which, in partnership with the part-time clinician, provide an intellectual center for Dermatology—a forum for discussion of problem cases and a learning center for the Dermatologists of all ages.

In the first 25 years of its existence, the Dermatology Foundation has established itself as an important source for funding for dermatology research, particularly research done by young investigators. More than 4.4 million dollars in fellowship and grant support have been awarded by its foundation in its first 25 years.<sup>9</sup> These monies have made a significant impact on dermatology specialty presence in the medical schools and on the quality of the Dermatology Educational Training Programs.

Where did most of these monies come from? Currently, 1702 dermatologists (almost all practicing) support the Dermatology Foundation at a level of \$100 per year or higher. This number represents 29% of the members of the American Academy of Dermatology. It may also be of interest that a new campaign was begun in 1990. The goal was to contact personally every dermatologist in the United States. It was estimated that if every dermatologist were to pledge the fee of one return patient visit per month, that more than 3 million dollars could be raised annually.

The specialty of otolaryngologists has a similar program. The American Academy of Otolaryngology, in 1990, launched a new 11 million dollar, 5-year cam-

paign. Their goals included increased research and training-grant support, continuing medical education support, and humanitarian efforts, such as supporting physicians in practice in under-served areas.

## CONCLUSION

I am convinced that the most important issue facing the specialty of allergy and immunology today is the support of our academic centers and their training programs. Our personal support of the AAAI Educational and Research Endowment Trust Fund will go a long way to help solve the problems that our specialty faces today!

John A. Anderson, MD  
President

*American Academy of Allergy and Immunology*

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