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Perspective

Creating an Adjunct Medical School for Primary Care Doctors

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Abstract

The United States faces a projected shortage of approximately 86,000 physicians by 2036, with the greatest impact in primary care and underserved regions. Concurrently, many qualified applicants are excluded from medical training due to limited enrollment rather than academic ability. Advances in broadband technology, online education, and modern anatomical teaching tools provide an opportunity to redesign medical education. We propose a hybrid medical school model placed within a tertiary teaching hospital. The program would recruit experienced healthcare professionals (e.g., nurses, paramedics, and corpsmen) and deliver preclinical education through online platforms and plasticized anatomical models, with clinical training conducted in hospital-based rotations. This scalable approach leverages existing infrastructure, reduces capital costs, and expands physician workforce capacity. The model aims to improve primary care training while addressing workforce shortages in underserved areas.

Keywords: *Physician Workforce Shortage, Hybrid Medical Education, Primary Care Training, Online Medical Education*

Introduction

The United States is experiencing a significant and worsening physician shortage, projected to reach approximately 86,000 physicians by 2036 [4], with primary care and rural regions disproportionately affected. This shortage is compounded by an aging population with increasing healthcare needs and a limited expansion of graduate medical education positions. Although new medical schools were established between 2008 and 2010 to address workforce gaps, these efforts have not sufficiently met national demand.

At the same time, medical school admission remains highly competitive, with roughly 60% of qualified applicants rejected annually due to limited training capacity rather than academic deficiency [1]. As a result, many students pursue medical education internationally, including at offshore institutions such as St. George's University, which has demonstrated comparable performance on licensing examinations relative to U.S. graduates.

Recent advances in digital learning platforms and broadband-enabled education, accelerated by the COVID-19 pandemic, have demonstrated the feasibility of hybrid and online medical education models. Additionally, innovations in anatomy teaching—such as plasticized human models—have reduced dependence on cadaver-based instruction while maintaining educational effectiveness [3].

Historical precedent also supports gradual expansion models in medical education, such as the University of Massachusetts Medical School, which successfully scaled its program to meet regional workforce needs [2]. Building on these developments, we propose a hybrid, hospital-based adjunct medical school model designed to expand primary care training while leveraging existing clinical infrastructure and modern educational technology.

The evolution of technologies from broadband internet networks to the preservation of plasticized human body forms—represents an incredible boon for any tertiary hospital in the United States.

The COVID-19 pandemic accelerated and serendipitously improved the widespread adoption of online study, learning, and even sophisticated education. What we propose in this paper can significantly benefit the economy and expand the pool of primary care physicians; certainly, the primary care physicians whom we train at such new schools can also be well utilized in rural areas. The need is at crisis level; the States will be very attentive to this proposal, recognizing the tremendous potential to serve elderly populations in underserved regions.

In fact, the United States has a shortfall of 86,000 physicians by 2036 [4]. This is especially troubling for the welfare of our nation as the population is aging disproportionally to the pool of primary care physicians. There will be fewer and fewer primary care physicians to care for more and more elderly patients. This issue has been addressed in only a small measure by the present federal administration. Indeed, 8 new medical schools were chartered and opened between 2008-2010 to help address this very urgent national issue.

Meanwhile, nearly 60% of U.S. college students who apply to medical school are rejected[1]. This is not a reflection of their abilities but rather an indication of how few spots exist to train the next generation of American doctors. Many of these rejected students pursue their medical education at offshore institutions such as St. George's University in Grenada, which accepts approximately 1,100 students per class—compared to the typical 100–120 at U.S. medical schools. Notably, St. George's students often perform as well or better on licensing exams than their U.S.-trained counterparts. The St George's students gain a fine education and their own inherent abilities shine through the difficulties of obtaining an education in a foreign land. Saint George's is just one example of 'off-shore' medical education; there are over 20 such 'for profit' medical schools of differing caliber throughout the Caribbean and other world venues including Poland, Australia and England to name a few.

The senior author served as an inspector for the Government of Grenada from 2009 to 2020, tasked with evaluating surgical education sites affiliated with St. George's University. It was very apparent to him that SGU provided a high-quality education for students who had not gained entry into U.S. medical schools. In 2020, many students expressed a preference for online learning, citing reduced costs and the elimination of the challenges associated with living abroad. These students noted that the costs were diminished and the insecurities of living abroad were absent because of the option of doing such courses on- line. Certainly those students who have less financial means may be well served by having the opportunity to go to medical school here in our hospital where one can have an adjunct medical college under the auspices of the local established medical school with a desire to do primary care. States would likely support such a plan, given the acute need for primary care physicians in rural areas. Federal support from HHS and the Department of Health, as well as military demand for primary care providers, would further bolster this initiative.

We propose selecting 25 individuals per year who have previously self-selected themselves for primary care medicine. These students would come from the ranks of nurses, nurse practitioners, and nurse anesthetists, dentists, senior EMS personnel, corpsmen from the armed forces all of whom have been involved in primary care in one form or another. We would accept the first class with the intention of ultimately expanding to 75. The initial class would eventually expand to 75 students. This trajectory and paradigm were successfully employed by the University of Massachusetts (UMass) in 1978[2]. Like UMass, we advocate building slowly, steadily, and strategically to provide a great service to the state and its economy. This paradigm will provide jobs, increase the revenue stream for small businesses in the area and monetize the sponsoring Medical Center itself with a burgeoning student revenue stream.

A teaching hospital campus is replete with state-of-the art -technology that could serve medical educational needs in the paradigm that we are proposing. The 'wired' hospital campus that is buttressed by the sponsoring medical school will allow it to function as a full service, full time online educational center for the first two years of medical education. "Bugs, drugs and Biochem" will easily be taught with the space capacity and the internet technology already in place; there is no need for any capital outlay whatsoever. The hospital has the classroom capacity requisite. We can, easily and with no disruptions to the daily functioning of the medical center, address all of the needs of a nascent medical college on campus.

The conundrum associated with this novel system of medical education is how to teach the subject of Anatomy effectively. Medical schools have historically utilized human cadavers in the classroom; cadavers, however, are expensive and preparing and maintaining them can be labor-intensive. Cadavers labs also necessitate a large capital outlay, and maintenance costs become exorbitant over time. Funding is often subsidized by research universities or other institutions of higher education. We believe that cadaver labs will soon be of historical note only. Inspection of Nova Southeastern University's new medical school in Fort Lauderdale, Florida showed us and our consultants that medical education no longer requires cadavers or cadaver labs to comprehensively teach Anatomy. 'Plasticized' human models, which are essentially exact-truly exact-replicas of the human body are being used there. Nova's medical students' anatomy exam results are far better than those of students at schools who continue to use cadavers[3]. The future of teaching the subject of Anatomy is upon us, and it plays perfectly into our paradigm for an online adjunct medical school.

The first two years of standard medical education can be accomplished quite easily if you incorporate modern technology to the existing hybrid of educational innovations, which can include contracting Phoenix University for its expertise in conducting online education combined with the use of plasticized human models and broadband technology housed within a common area on campus easily accessible to medical students. Students are willing to pay up to $80,000 in tuition to attend medical school in the United States, and housing can be offered at a profitable rate. The financial rewards are self-evident, and as class sizes increase and the logistics run smoothly, the revenues will continue to increase while students receive a quality education. The hospital will be rewarded financially in addition to knowing that the nation is being provided for by men and women steeped in our deeply-held convictions regarding the value of life and the goal of alleviating suffering.

The third and fourth years of medical school can be carried out here at the teaching hospital. All of the rotations can be easily set up to accommodate the twenty-five students whom you will select. Surgery, obstetrics and gynecology, psychiatry, internal medicine and pediatrics each have an educational infrastructure already in place for medical students. Our plan would encompass the education strictly of those students selected for our nascent medical school. The area surrounding the school would profit economically, the hospital itself would receive a revenue stream that is rich and consistent without outlays of capital.

When it comes to securing the financial support necessary to establish a new medical school, funding can be sought from an affiliated medical institution whose leadership maintains a close working relationship with ours. To enhance the likelihood of our proposal being approved by the appropriate educational authorities, I recommend structuring our prospective online medical school as an affiliated branch of an established educational institution. This partnership would allow the program to operate under the umbrella of the parent school while retaining a degree of independence—similar to the relationship between commonwealth territory to the United States or the United Kingdom. The new school would maintain control over its curriculum while remaining formally connected to its parent institution, with joint branding reflected on its degree certificates.

Based on the senior author's expertise, this has led us to the conclusion that if such success can be accomplished on a rock in the middle of the sea, where medical students were housed and educated in Quonset huts, then we can achieve even greater success here. This epiphany, coupled with our knowledge of the educational innovations and capabilities of Phoenix University and the Southern New Hampshire University, underscore our moral compulsion to cobble together an innovative hybrid that will educate and populate regions of low physician density. Our plan can come into fruition today secondary to technological breakthroughs in both broadband internet utilization and the development of artificial cadavers. Such an initiative would not only generate new revenue streams for the associated healthcare system but also provide meaningful benefits to the broader community and state.

Conclusion

The United States faces a significant projected physician shortage, particularly in primary care, requiring innovative approaches to medical education. Current training capacity limits restrict entry despite strong applicant pools. A hybrid model integrating online preclinical education, simulation-based anatomy, and hospital-based clinical training offers a scalable solution. Leveraging existing tertiary hospital infrastructure reduces capital costs while expanding educational capacity. Prior offshore medical education systems and domestic expansion models demonstrate feasibility and workforce impact. Institutional growth strategies, such as those used by the University of Massachusetts Medical School, further support gradual scaling. Advances in plasticized anatomical models also reduce dependence on cadaver-based instruction. This model provides a sustainable framework to expand physician training and improve access to care in underserved areas.

Conflict of Interest

The authors declare that they have no conflicts of interest.

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