



Statement
of the
American College of Surgeons

Presented by

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before the
Committee on Small Business
United States House of Representatives

**“The Looming Challenge for Small Medical Practices:
The Future Physician Shortage
And
How Health Care Reforms Can Address the Problem”**

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Chairwoman Velazquez, Ranking Member Graves, and Members of Committee, the American College of Surgeons (College) is grateful to you for holding this hearing on the challenges facing our nation's healthcare workforce. I am Dr. George Sheldon, and I am honored to represent the College, which includes more than 74,000 surgeons worldwide. I am currently Professor of Surgery and Social Medicine at the University of North Carolina-Chapel Hill. I also serve as the Director of the American College of Surgeons Health Policy Research Institute and am a member of the Institute of Medicine. I have also previously served as President of the College, Chair of the American Board of Surgery, and President of the American Surgical Association. In 1985, I was also appointed to serve as a charter member of the Council on Graduate Medical Education (COGME).

Surgery in the Context of Reform

Surgeons in the United States are responsible for over 30 million operations annually and are an essential part of modern health care. Last year, the College issued a comprehensive document that outlined principles for healthcare reform. As we are now at a period of intense focus on how this might be best done, we are honored to have the opportunity to offer our input and to contribute to today's discussion of the challenges facing our nation's healthcare workforce.

While we all are anxious to improve our healthcare system, it is important to note the benefits the current healthcare system has given us. I want to bring your attention to an editorial by Nobel laureate Gary Becker titled, "Longer Life was the Greatest Gift" (Business Week, Jan 31, 2000). Becker notes that we have almost doubled the life expectancy of Americans in the last 100 years. This is unprecedented in the history of human experience. While many things contribute to a healthy environment, a healthy population is a stable population. For example, it was a poor health care system that resulted in an unhealthy and unstable population in the former Soviet Union. It has been documented that this instability and the poor health of the Soviet population played a significant role in hastening the Soviet Union's ultimate collapse in 1991 (Notzon, FC, Komarov YM, Ermakov SP: Causes of Declining Life Expectancy in Russia. JAMA 1998: 279-793). In short, as we go through healthcare reform, it is important not to "throw the baby out with the bath water" and create a new system that undermines the great achievements of our health care system that have served to produce a more healthy and stable population. While there is certainly room to improve and areas that we must address, it is important that we build on what has worked and that we base our action on a clear understanding of what the true problems are and not what we may perceive them to be.

While the College appreciates the White House's attention to health care reform, we are concerned about the assumptions embodied in the June 2nd publication of the White House Council of Economic Advisors titled, "The Economic Case for Health Care Reform, in which they endorse the concept that a 30 percent reduction in health care costs can be achieved by addressing the issue of regional variations in spending and

doing so, in part, through the False Claims Act. This position is one that has been articulated by researchers at Dartmouth in the Dartmouth Atlas and in numerous other publications and forums as well. This position, however, is based on limited, focused data that relies only on Medicare and a set of arbitrary boundaries to assess costs and rates of activity. Moreover, it does not include total costs invested in the health care system by all payers, and it essentially attempts to mix apples and oranges when making comparisons between the health care expenditures of rural and urban areas. This Dartmouth position has led to a lively national debate, with contrary data being generated by respected investigators, such as Robert Berenson, M.D. of the Urban Institute, Thomas G. Ricketts, Ph.D. of the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, and Richard A. Cooper, M.D. of the Wharton School of Business at the University of Pennsylvania. In short, the Dartmouth results have neither been replicated nor fully validated to the point that they ought to be used to set national public health policy, as was noted in a June 8, 2009 Wall Street Journal editorial. Many have articulated the belief that healthcare costs are extracting valuable funds from American industry and getting the costs under control will benefit our overall economy. While agreeing with that to a point, it is important to note that healthcare itself is an industry, and one in 55 people work in health care. In fact, it is the only part of our economy that has not lost jobs during the current recession.

We also are concerned at the seeming tunnel vision of many proposals that focus only on specialties that fall under the broad rubric of primary care. When considering primary care, it is important to remember that modern health care comprises a spectrum of providers of which physicians only comprise 7 percent of our nation's health care workforce. We support primary care and subscribe to the definition provided by the Institute of Medicine, which in 1992 properly defined primary care as a service and not a specialty. In other words, it is a needed service for all patients but one that can be provided by a spectrum of providers, including non-physician practitioners (Donaldson M, Yordy K, Vanselow N., eds. *Defining Primary Care: An Interim Report*, National Academy Press, 1994). The primary care physician, the internal medicine specialist, the family practitioner, the pediatrician, and the advanced practice nurse all have a spectrum of overlap in the primary care services they provide. In contrast, surgeons are uniquely qualified to provide necessary and life-saving procedures that no other professional, including other physicians and even other surgeons, can provide. For example, a general surgeon will do a spectrum of procedures but usually is not trained to do neurosurgery or more complex parts of other surgical fields. Even in our larger communities, a urologist and a neurosurgeon cannot cross cover for each other in urgent or elective procedures. In short, the needed services of surgeons, which account for an essential part of our healthcare system, are under great stress because there are more limited numbers of surgeons who are qualified to provide these services to patients.

The Surgical Workforce – A Growing Crisis

Today, we are here to discuss a crisis shortage of essential healthcare providers, including surgeons. My comments will largely focus on the largest surgical specialty, general surgery, but other surgical specialties including urology, orthopaedics, neurosurgery, and cardiothoracic surgery are also facing significant workforce challenges. In 1981, the American Board of Surgery provided certification for 1,047 general surgeons graduating from accredited training programs. In 2008, the American Board of Surgery certified 1,032. Today, there are approximately 4 percent fewer general surgeons than a decade ago, and this has translated to a 20 percent decline in the number of surgeons per population over the past ten years. Since 1981, the number of general surgeons completing residency has been almost constant, hovering around 1,000 graduates each year. In that same period of time, the population of the United States has increased by 25 million people each decade.

Critical access areas in rural America are rapidly losing general surgeons, as illustrated on the provided map. These areas encompass about 59 million people—approximately twenty percent of the American population. Surgical services are essential for small community hospitals in these areas. These hospitals rely on having surgical services for their financial health. Without surgical services, these hospitals often close, and as a result, obstetrical services, primary care services, and other important services often cease to be provided as well. Moreover, the small hospital is often the largest employer in the community, meaning that the closure of a hospital in small community leaves an economic vacuum that is not easily, if ever, filled. In addition, businesses, especially those of a high-tech nature, which might consider locating in smaller communities, rarely if ever choose a community where there are no identified healthcare services in the immediate area. In short, the general surgeon shortage not only has implications for the delivery of health care services but it also has implications for our local hospitals and economies as well. It is for these reasons that the shortage has reached crisis proportion, and, therefore, it would be a serious oversight in public policy not to use the opportunity before us now to address it.

Every specialty of surgery has fewer surgeons entering practice than twenty years ago (Dartmouth Atlas). All surgical specialties have an increasingly older profile with one third of all surgeons over 55 years of age. Some specialties, such as cardiothoracic surgery, are actually closing some of their training programs as the emphasis in American medical schools has shifted increasingly to primary care. These trends are complicated by the fact that the services provided by surgeons cannot be replicated by other health providers. For example, in emergency services it is vital to have a general surgeon to deliver trauma care. To ensure that surgeons are trained to provide this essential, life-saving care, and to ensure that surgeons have the support they need, the American College of Surgeons has established the Trauma Verification Program. This has provided a strong safety net, which was not present even twenty-five years ago. It relies on a spectrum of providers, from ambulance drivers, emergency medical technicians, emergency room physicians, and others. The critical element of the program is the leadership, most often provided by a general surgeon, who brings in a

spectrum of involved specialists in other branches of surgery, such as neurosurgery and orthopaedics, to meet the needs of patients.

Trauma remains the most common cause of death for Americans under the age of forty and the fourth highest overall. Trauma is responsible for the most years of potential productive life lost (YPPL). Studies show that when optimal trauma care is available, 25 percent of trauma-related deaths can be avoided.

Cardiac disease is the most common cause of death overall. Great progress has been made with mortality from heart disease, which is now half of what it was in 1950. The paradox of its remaining the most common killer is that medical and surgical interventions have allowed the patient with acute cardiac disease to be treated effectively and often live fifteen to twenty-five or thirty years of productive life after an acute event. In spite of these added years of life, patients often will still succumb to heart disease, but of a different mechanism. Unfortunately, the ability to continue extending heart disease patients' lives could be complicated by the fact that we are now not only dreadfully short of cardiothoracic surgeons needed, but we also lack the needed numbers of cardiothoracic surgeons in training as well.

The second most common cause of death, cancer, relies heavily on surgery for the diagnosis and therapy. In fact, nearly eighty percent of all cancers that are cured are done so by the intervention of surgery. Cancer care most often requires a team approach in which surgeons, medical oncologists, and a variety of other health providers pool their skills and devise a plan that involves surgery, adjunct therapy, and other interventions. Survival rates for breast cancer, colon cancer, and other cancers are higher in the United States than in any other country in the world (OECD data). These are but a few examples of how surgical and medical specialists have helped create a healthier and stronger America.

Surgery's Unique Challenges

The long-term outlook for surgery brings added stress to the surgical profession which contributes yet another factor for fewer medical students and residents to choose a career in surgery. Unlike many other medical specialties, there are no good substitutes or physician extenders for a well-trained general surgeon or surgical specialist. Moreover, surgical training is vastly different from other physician training programs. Mastery in surgery requires extensive and immersive experiences that extend over a substantial period of time. Whereas non-surgical residencies can be completed in as few as three years, surgical residencies require a minimum of five years and often several more for specialties such as cardiothoracic surgery. Of course, the rigor of a surgical residency is certainly not for everyone: the work hours, sleep cycles, and intensity fit a surgical resident's personality much in the same way dermatology, internal medicine or pediatrics fits another. However, the prospects of declining payment coupled with rising practice costs; increasing liability premiums and the escalating threat of lawsuits; a diminishing workforce leading to more on-call time, higher caseloads, and

less time for patient care; and an uncertain future for the U.S. health care system—all of these factors understandably deter would-be surgeons from making the extra sacrifices necessary to become a surgeon.

The decrease in the numbers of general surgeons most directly impacts the 54 million Americans who are cared for in small and rural hospitals. While some of the rural workforce challenges relate directly to the difficulty in recruiting surgeons to those areas, some are also the result of a lack of workforce reinforcement. For instance, the level of on-call time is greatest in rural areas; in some cases, general surgeons are forced to take call 24 hours a day, 7 days a week. Needless to say, after spending several intensive years in residency, such a requirement may not, understandably, be an attractive one for a surgeon who has likely already sacrificed several years of family time during training. In addition, because of economic and other forces beyond their control, older surgeons in rural areas know that retirement or a less stringent workload may be further off than planned. Surgeons in rural areas also have a lower day-to-day volume of the types of procedures they are expected to perform at any given moment, making them less confident about the quality of care they will be able to provide and adding to liability concerns. For those who stay in rural areas, these issues are of great worry, and many surgeons are choosing to leave rural areas for the relative professional security of a more populated place to practice.

Solutions—Preserving and Improving Access to Surgical Care

The American College of Surgeons has developed several proposed measures and would be open to other solutions that improve patient access to surgical care and ensure the needed surgical workforce in the future. Foremost is the need to support the residency programs that already exist and to promote the development of additional residency programs as well, particularly in rural areas. In addition, it is important to develop appropriate supports and incentives for medical students who are interested in pursuing a surgical career while also eliminating the disincentives that push medical students away from the surgical profession. To this end, the American College of Surgeons would encourage the Congress to strongly consider the following policy options:

- Preserve Medicare funding for graduate medical education (GME) and eliminate the residency funding caps.
- Fully fund residency programs through at least the initial board eligibility.
- Include surgeons under the Title VII health professions programs, including the National Health Service Corps (NHSC) program, making them eligible for scholarships and loan assistance in return for commitment to generalist practice following training.
- Alleviate the burden of medical school debt and promote rural/underserved care through loan forgiveness programs that stipulate work in rural/underserved areas.

- Extend medical school loan deferment to the full length of residency training for surgeons.
- Allow young surgeons who qualify for the Economic Hardship Deferment to utilize this option beyond the current limit of three years into residency.
- Increase the aggregate combined Stafford loan limit for health professions students.

Two pieces of legislation have been introduced that are consistent with our proposed solutions. While our preference would be to lift the present caps in GME funding entirely, the College supports the “Resident Physician Shortage Reduction Act of 2009” (H.R. 2251), which has been introduced by Rep. Joe Crowley (D-NY) and would take an important step of addressing physician workforce shortages by raising the number of Medicare-funded residency slots by 15 percent over current levels. The College also supports the “Access to Frontline Health Care Act of 2009” (H.R. 2891), which has been introduced by Rep. Bruce Braley (D-IA), that would offer loan repayments to relieve some of the staggering debt burden faced by many health professionals, including general surgeons, ophthalmologists, and otolaryngologists, that are in short supply but high demand in underserved areas. This assistance would allow surgeons in these specialties who are motivated to care for underserved communities to enter and complete training that might otherwise be unaffordable to them. The loan repayment would free them to take a career path that may be less lucrative, but more satisfying. Communities identified as “frontline shortage areas” would gain access to needed health care services that could continue after the minimum time commitment has ended.

In addition, the American College of Surgeons also supports legislation that seeks to increase the number of residency training programs. At present, most residency training programs exist in or near major metropolitan cities. While the current programs continue to excel at producing high quality surgeons, they do not adequately distribute surgeons to communities across the nation. A major obstacle often preventing the establishment of new residency training programs are the costs associated with the creation of such programs. The Physician Workforce and Graduate Medical Education Enhancement Act (H.R. 914), which was introduced by Representative Michael Burgess, MD (R-TX) and Representative Gene Green (D-TX), would establish an interest-free loan program where hospitals committed to starting new residency training programs in one or a combination of seven medical specialties, including general surgery, could secure start-up funding to offset the initial costs of starting such programs. By providing a greater number of residency training programs in previously underserved areas, the surgical workforce shortage could be reduced for many states. In addition to the measures previously discussed, the American College of Surgeons believes this legislation would be an appropriate step toward addressing the workforce challenges we are witnessing in rural areas. The American College of Surgeons will continue to support this and other legislation that helps ensure patient access to surgical care.

Surgeons complete their training and enter their profession with full knowledge that certain requirements will be made upon their time and family life, and this includes

serving on on-call panels for emergency and trauma care situations. Yet, as has been already noted, there are structures and disincentives within our current health care system that complicate this task and complicate surgeons' ability to provide the emergency and on-call services on which all Americans depend. In addition, these on-call responsibilities can be particularly significant in rural and lesser populated areas, further complicating efforts to recruit surgeons to these areas. To support these surgeons' commitment to provide emergency surgical care, particularly in rural areas, and to help avert an emergency surgical workforce crisis, the College encourages consideration of the following measures:

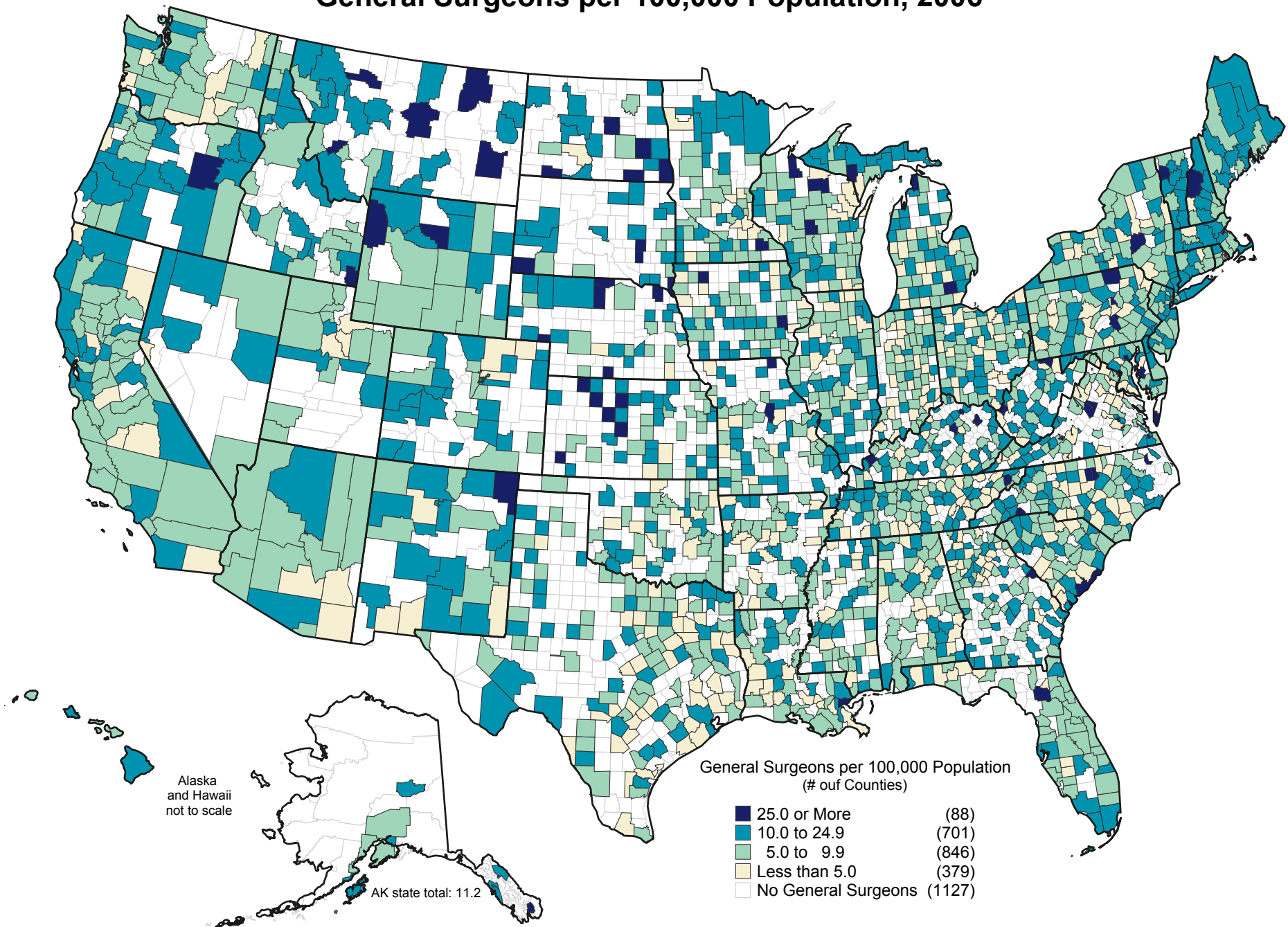
- Include surgeons in bonus payment structures for health professional shortage areas.
- Allow surgeons access to Medicare's disproportionate share program, currently restricted to hospitals, when they operate on patients they see in the emergency department (ED) or as a result of care provided under the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA).
- Provide tax relief to surgeons who perform EMTALA-related care. This could be based on overhead costs as related to the Medicare physician fee schedule.
- Adjust Medicare practice expense pools for each specialty to account for uncompensated care related to ED or EMTALA-related care as is done for emergency medicine.
- When hospitals pay stipends to surgeons who take emergency call, Medicare should recognize these costs as is currently done for critical access hospitals.
- Provide liability reform for surgeons who perform EMTALA-related care.
- Expand the Federal Tort Claims Act to include surgeons who provide services to patients who are referred through their primary care physician at a community health center.

Finally, the most immediate challenge for patient access to surgical care is the precarious payment situation confronting surgeons and surgical practices. Medicare payments to physicians will be cut 21.5 percent on January 1, 2010 if Congress does not act. The American College of Surgeons calls on Congress to take action to stop this cut, to provide an increase in Medicare payments for all physicians in 2010, and to initiate reform for Medicare's physician payment system this year. The College greatly appreciated Congress's passage of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) last July that reversed the 10.6 percent cut in Medicare physician payments. In addition, MIPPA included the largest Medicare payment increase for physicians since 2005 by replacing a scheduled 5.4 percent cut in 2009 with a 1.1 percent increase this past January. MIPPA also made changes to how physician work was valued under Medicare, increasing payments for some surgical services. In spite of these important measures, Medicare payments for many surgical procedures have been reduced significantly over the past twenty years and, in some cases, they have been cut by more than half from reimbursement levels in the late

1980's. In spite of these payment trends and the workforce challenges just outlined, some, most notably the Medicare Payment Advisory Commission (MedPAC), have proposed financing increased reimbursement for primary care by simply cutting reimbursement for care provided by other physician specialties. Such proposals, while seeking to promote efforts to help Americans better manage their care, would further exacerbate the workforce challenges previously described and ironically establish a reimbursement structure that would ultimately undermine patients' ability to access the life-saving acute care services that only surgeons are qualified to provide. After all, increasing Americans' access to health insurance coverage will have little value if Americans cannot obtain the care they need from the appropriate physician. As a result, it is critical that Congress take steps now to ensure a stable surgical and a stable physician workforce for all Americans for years to come. The College supports efforts to prevent disease and to manage patient care not only because it is in the best interests of the patient and health care system but also because, when these patients need surgery, they are much less likely to encounter complications and much more likely to recover quickly from the operation. However, regardless of how well patients' care is managed, acute situations requiring prompt and definitive access to surgical care will continue to occur.

Thank you for the opportunity to testify regarding these important challenges facing our nation's surgical workforce. The College remains committed to enacting reforms that preserve and further patient access to surgical care and to the range of important services provided by our colleagues in medicine. The College looks forward to working with you and with the Congress to enacting measures to address the surgical workforce crisis. This includes stopping the pending Medicare payment cut and initiating much needed reforms of Medicare's payment system this year. The American College of Surgeons stands ready to work with you to ensure that all Americans will continue have access to the comprehensive health care services that America's surgeons and physicians provide.

General Surgeons per 100,000 Population, 2006



Sources: AMA Physician Masterfile, 2006; US Census Bureau, 2006.
 Data include clinically active, non-resident, non-semiretired physicians indicating a general surgical specialty.

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