From my perspective

All surgeons are affected by the workforce issue at some level, whether it's a matter of trying to recruit a new partner or ensuring that the local hospital has an adequate number of emergency room physicians and trauma surgeons. And, of course, medical schools, training institutions, and the certifying boards need to determine the public's need for surgeons and physicians of all specialties. So the physician supply issue really is a global one.

Today, concerns about the medical workforce are reemerging, as evidenced by a recent article in the *New England Journal of Medicine* that examined the ongoing debate over whether we have a surplus or a deficient supply of generalist and specialist physicians.* The workforce issue has been, and continues to be, an important one because it has implications for our entire health care delivery system.

The key question regarding the issue of workforce is what impact the changing nature of the work that we do will have on the size of the surgical workforce we will need.

Ongoing topic of debate

In the last few decades, several workforce studies were completed by national medical education panels, including those done by the Graduate Medical Education National Advisory Committee (GMENAC) and the Council on Graduate Medical Education (COGME). These surveys analyzed the number of medical school graduates and their impact on the total physician workforce. The GMENAC report, for example, took 10 years to develop and attempted to forecast the supply of and need for physicians in the years 1990 and 2000. The panel concluded that by the year 2000, the U.S. would have a surplus of 145,000 physicians if medical schools continued to produce the same number of graduates and if international medical school graduates continued to immigrate at the same rate as they did at the time the study was conducted.

Throughout the 1990s, COGME produced a series of reports that also indicated that the U.S. would have an excess number of physicians by the year 2000. COGME further predicted particularly dramatic growth in the number of specialists, and warned of a possible dearth of generalists, such as family practice physicians, internists, and pediatricians. Following these reports, a number of initiatives were debated—and sometimes instituted—at the national level to control the number of physicians, particularly specialists, entering the workforce.

For the last few years, concerns about physician supply have often been superseded by growing concerns about managed care, Medicare reimbursement, and other issues. However, Richard Cooper, MD, former dean of the Medical College of Wisconsin, and others recently reopened the debate. Dr. Cooper and his colleagues assert that there has been a strong correlation between the gross domestic product per capita, the growth of the population, and the number of physicians in the U.S. They claim that this correlation reflects underlying causal links between the nation's prosperity, the number of people who are demanding medical services, and the consequent need for health care professionals.†

*Blumenthal D: New steam from an old cauldron—The physician-supply debate. *N Engl J Med*, 350(17):1780-1787, 2004.

†Cooper RA, Getzen TE, McKee HJ, et al: Economic and demographic trends signal an impending physician shortage. *Health Aff*, 21(1):140-145, 2002.

Further complicating the debate are questions about how many physicians are really needed and about the value of the medical services needed by the population at large. Some experts argue that a large number of physicians simply inflates health care spending and leads to the provision of more services, some of which may be unnecessary. Other analysts claim that a leaner workforce will contribute to a more efficient, less wasteful health care system. This is the train of thought that was applied in the creation of health maintenance organizations that followed the group or staff model.

Factors to consider

As we discuss and deliberate on this subject and the direction we need to take over next five to 10 years, we need to consider it in the context of other changes that are taking place within graduate education and the health care delivery system. For instance, the actual work that will be done will undoubtedly undergo considerable change during that period of time.

For example, we are developing many new treatment options to control infectious diseases that allow patients to receive most of their care on an outpatient basis. Hence, the resources and the number of physicians that are needed to provide services to patients with AIDS, for instance, are far fewer than they were 10 years ago. Similarly, the need for surgical intervention in the treatment of peptic ulcers has basically been eliminated because of new advances in drug therapies. So, we need to think about what types of physicians are going to be most necessary to treat patients with conditions that may be best managed on an outpatient basis.

We also need to be mindful of the fact that we are going to be operating on patients who are older and sicker than the people who were receiving surgical care in the past. Indeed, not long ago many of the patients on whom we operate today would have been denied surgical care because of their age or health status. We must consider the possibility that new pharmaceutical approaches could be developed to treat these patients, as well. If that happens, the need for surgical specialists will again decline.

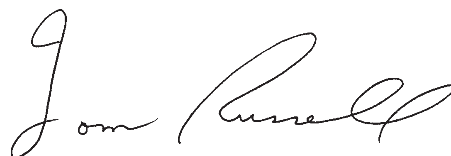
Also affecting the surgical workforce issue is the fact that surgical procedures may be replaced by more disease-specific approaches, rather than specialty-directed options. Treatments that are targeted at curing disease processes require a blending of skills and knowledge from a spectrum of specialties, as opposed to the highly specific competencies that specialists traditionally have attained. Furthermore, lifestyle interests and advancements in technology make some specialties more attractive to young surgeons than others are.

Undoubtedly, new specialties will be born as we strive to meet the fluid and evolving needs of our patients and our health care system. One example of a new specialty that is starting to gain recognition is "emergent surgery." The individuals in this specialty—known as "hospitalists"—would be responsible for the admission to the hospital of emergency room patients who are experiencing trauma or other acute surgical problems. It is also possible that we may see more surgeons receiving training that is tailored to the provision of care in rural settings or in "boutique" hospitals.

Conclusion

Worries about sheer numbers and supply and demand were the original sources of controversy about physician supply and the surgical workforce. As Blumenthal's article points out, over the years, miscalculations by the groups that have studied the medical workforce, changes in patient needs, advances in technology, and so on, have made the problem ever more complicated and abstract.

The reality is that there will always be a need for surgeons. The key question regarding the issue of workforce, however, is not how many surgeons we will need. Rather, it is what impact the changing nature of the work that we do will have on the size of the surgical workforce we will need to provide care for individuals who require our services.



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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.