

From my perspective



So many issues affect the ability of surgeons to provide adequate care to patients. Some of these problems seem to have a more profound impact on certain specialties than on others, but many have global repercussions for the profession. One subject that should be of great concern to all surgeons at this time is the ensuing surgical workforce shortage in this country, particularly with regard to its implications for emergency and trauma care.

Conventional wisdom

Not so long ago, experts studying the supply and demand of physicians in this country warned that by now, we would have a glut of physicians. For example, in 1981, the Graduate Medical Education National Advisory Committee (GMENAC) issued a report indicating that if physicians continued to be trained at what was the current rate at that time, the U.S. would have a surplus of 145,000 physicians within 20 years. Hence, the GMENAC report recommended restricting both the number of admissions to medical schools and the number of graduates of international medical schools permitted to immigrate.

Throughout the 1990s, the Council on Graduate Medical Education (COGME), created by Congress in 1986, issued a series of reports that also projected an oversupply of physicians, especially specialists, by the turn of the century. To address this situation, COGME recommended policies to ensure that 50 percent of new physicians would enter primary care, and the other 50 percent would enter specialties. The council also suggested limiting the number of positions available for residency training in U.S. hospitals to 110 percent of the number of U.S. medical school graduates.

Emerging crisis

However, more recent studies conducted by Richard Cooper, MD, former dean of the Medical College of Wisconsin, Madison, question previous assessments of the medical workforce, and especially the need for primary care physicians versus specialists. Based on an analysis of the causal links between the nation's wealth, its demand for health care services, and the expectation that medical professionals deliver these services, Dr. Cooper and his colleagues project that the need for specialty

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services will actually increase more rapidly than will the need for primary care.

The increasing need for specialty services is already apparent in our hospital emergency rooms. In a 2004 study conducted by the American College of Emergency Physicians, two-thirds of emergency department (ED) medical directors reported inadequate on-call specialist coverage. Additionally, we recently asked the various surgical board representatives whether they anticipate a shortfall in their members' availability to cover emergencies. Each specialty polled voiced a similar sentiment: a shortage in the number of surgical specialists willing to cover calls from emergency rooms is imminent.

Given the urgency of the situation, we recently held a meeting of surgical specialty societies to address emergency workforce issues. We sought to determine which specialties are most needed in the ED and what factors are contributing to the crisis.

Contributing factors

Clearly, too few surgeons are being trained in some specialties, possibly because of the restrictions emanating from GMENAC and COGME. However, a number of other circumstances appear

to discourage specialists from taking emergency call.

Some specialties report that they find it impractical to provide full-service emergency care and still be able to handle a regular caseload. Many surgeons have opted to subspecialize in order to enhance the efficiency of their practices, to a point where they ultimately feel poorly qualified to provide the broad scope of services demanded in the emergency department. Other surgeons feel that they are trapped between declining reimbursement and rising practice expenses.

Furthermore, the skyrocketing cost of professional liability insurance in some states is putting strain on trauma centers. For example, in July 2003 the only Level I trauma center in Las Vegas, NV, closed for 10 days because of the prohibitively high cost of professional liability insurance for many specialists. Limiting the scope of services they provide and their liability exposure to high-risk patients are among the few options available to surgeons seeking to rein in their premium costs.

Another factor inhibiting specialist participation in on-call panels is the Emergency Medical Treatment and Active Labor Act (EMTALA). Passed in 1986, EMTALA originally was intended to ensure that every emergency patient would receive care, regardless of his or her ability to pay. Since its passage, the law has been subjected to numerous regulatory and legal interpretations, which have had perverse consequences. In fact, many specialists have resigned from trauma panels after widely publicized instances of physician sanctions under this law incited concerns about unwarranted legal exposure for physicians who provide trauma care. Others, particularly those in smaller specialties such as neurosurgery, have found that strict interpretation of EMTALA's on-call requirements can be so onerous that it interferes with their elective surgery schedules.

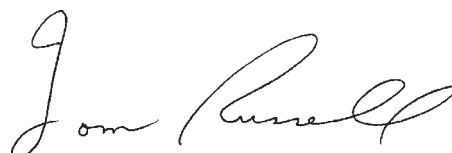
Additionally, the evolving role of the "general surgical trauma specialist" is proving to be a barrier to participation by other specialties. Thanks to advanced technology, many trauma and critical care patients are treated and monitored through nonoperative means. Hence, there is the potential for a new surgical specialty to emerge, which would center on providing acute care to those patients who do require prompt surgical intervention. These general surgical trauma spe-

cialists could perhaps be likened to the "hospitalists" and their effect on internal medicine. In other words, if there is a gap in providing care, someone will fill it.

Need to respond

It is of the utmost importance that the College and the surgical specialty societies work together to avert the pending ED coverage crisis. This problem already is putting great stress on hospitals and on the emergency physicians who need surgical assistance. If these issues are allowed to fester, it is ultimately the patients who need emergency care who will suffer the consequences.

To help alleviate this condition, it has been suggested that the College call for increases in resident training positions, clarification of EMTALA requirements, a rational payment system for full-service hospitals, regionalization of emergency care, and the development of a board of acute surgery. I anticipate that we will continue to discuss these and other ideas with the surgical specialty societies. Because many of you are affected by this situation, I would welcome any input you can provide about how it is playing out in your institution, as well as any suggestions you might have for bringing this situation to a positive resolution.



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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.