
On March 29, 2005, ACS Executive Director Thomas R. Russell, MD, FACS, and ACS Regent and Trauma Consultation Committee Chair Brent Eastman, MD, FACS, convened a meeting of the surgical specialty societies to discuss emerging issues regarding the surgical workforce and the future of emergency and trauma care. The purpose of this gathering was to initiate a dialogue among the specialties regarding the nationwide problem of inadequate surgical specialty coverage for emergency care. Participants also sought to determine the potential leadership roles of the specialty societies and the College in confronting this challenge.

Although the organizations did not agree on one clear path for solving the problem, they did reach a general consensus regarding the many factors that have contributed to it and on a range of options that merit further review. This article summarizes highlights of the discussion.

ACS and surgical specialty societies review emergency workforce issues

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PHYSICIAN WORKFORCE CRISIS

According to Edward Salsberg, director of the Center for Workforce Studies at the Association of American Medical Colleges (AAMC), the science of forecasting physician supply and demand is still evolving, but it is apparent that earlier predictions of an oversupply of specialists and an undersupply of primary care physicians missed the mark. Despite improvements in methodology, however, current efforts to forecast both supply and demand remain hampered by the following factors: uncertainty about the future role of international medi-

cal school graduates, retirement patterns among the growing number of woman physicians, lifestyle demands of younger physicians, the future role of nonphysician providers, and the ability to retrain physicians in practice.

To meet the anticipated significant increase in demand for physicians, the AAMC recommends a 15 percent increase in medical school graduations by 2015. To meet this goal, the AAMC suggests the following: (1) eliminating the cap on the number of residents that Medicare graduate medical education payments support; (2) expanding public and private research and analysis; (3) provid-

ing medical students with up-to-date data and information for career plans and specialty choice; and (4) promoting efforts to address the needs of underserved areas and populations through an expansion of the National Health Service Corps and other efforts to develop a diverse workforce. Mr. Salsberg explained that important policy questions for the specialty societies will continue to emerge as the physician workforce evolves to meet increasing demand.

SPECIALTY ON-CALL COVERAGE

James Mitchiner, MD, FACEP, representing the American College of Emergency Physicians (ACEP), presented information on emergency department overcrowding and specialty coverage.

Dr. Mitchiner explained that the updated 2003 Emergency Medical Treatment and Active Labor Act (EMTALA) regulations remain a contentious issue between hospitals and physicians. These regulations have had a paradoxical effect on access, leading to reduced specialty on-call coverage and increased “dumping” to tertiary hospitals. Surveys that the California Medical Association and the U.S. Department of Health and Human Services Inspector General conducted have indicated that the on-call problem is somewhat serious for certain specialties, notably plastic surgery, neurosurgery, neurology, and thoracic surgery. According to the 2000 American Medical Association Physician Marketplace Report, 61 percent of general surgeons and 33 percent of surgical subspecialists report giving EMTALA-mandated care during a typical week. Bad debt related to this care is significant: 27 percent of total bad debt for general surgeons and 17 percent for subspecialists.

Dr. Mitchiner described the following options for hospitals attempting to meet the EMTALA on-call regulations: (1) enforce on-call responsibilities; (2) hire specialists/“hospitalists” for specific on-call duties known as “exclusive contracts”; (3) pay per diem stipends; (4) guarantee reimbursement per case or per relative value unit; (5) institute a hybrid model that includes a stipend and a payment guarantee; (6) offer hospital-paid medical liability coverage; and/or (7) require emergency department on-call service as a condition for obtaining hospital privileges.

IMPACT ON TRAUMA CENTERS

J. Wayne Meredith, MD, FACS, Chair of the ACS Committee on Trauma, discussed the specialty coverage problem and its effect on trauma centers. Dr. Meredith described the trauma care coverage problem as an economic issue. Reimbursement, not physician ethics, is the root cause of the problem, he said. As the demand for trauma care continues to increase, the supply of trauma caregivers is determined by the ability of qualified caregivers to enter the trauma care “market” or industry. Present barriers prevent surgeons who practice in community hospitals, specialty hospitals, and ambulatory surgical centers from joining trauma centers. Certainly, EMTALA regulations have resulted in specialists relinquishing hospital privileges to avoid emergency call responsibilities, partly due to litigation fears. New obstacles to recruiting surgical residents into trauma care also have arisen, including the increasingly nonoperative nature of the work as well as lifestyle issues.

ADDRESSING THE CRISIS

Dr. Eastman described the “perfect storm” of convergent forces that led to the specialty coverage crisis in emergency and trauma call panels. Decreased reimbursement, fewer medical school applicants, an aging surgeon population, lifestyle issues, liability threats, and unintended consequences from EMTALA all play a large part. He noted that when chairs of the surgical boards were asked recently whether they anticipated a sufficient number of specialists to provide adequate coverage of emergency department and trauma call panels in the next five years, every one of them replied, “No.” He warned that this crisis is being inadequately addressed at the national and local levels, and that the specialty societies must decide how to address the situation or risk further erosion of the emergency care safety net.

Dr. Eastman also presented for consideration and discussion among the specialty societies such relevant issues as:

- Increasing the number of surgical specialists being trained.
- Addressing geographic distribution problems.

- Examining the issue of fair payment.
- Integrating the trauma system into the emergency system/disaster planning.
 - Regionalizing for more efficient use of limited surgical specialists according to a “trauma model.”
 - Developing exclusive contracts for unassigned emergency patients.
 - Creating hospital-supported reimbursement methods such as stipends or payment guarantees.

According to Dr. Eastman, steps should be taken to integrate trauma, emergency, and disaster planning systems. He also noted that the future of emergency care in the U.S. depends on the availability of surgical specialists for the emergency department and trauma call panels. The specialty societies must join forces and face this challenge together, he added.

A NEW SPECIALTY?

The future of trauma surgery as an attractive field of practice has been the subject of much discussion throughout the nation. One idea under consideration in the trauma community is the introduction of a new specialty of emergency or acute care surgery, practitioners of which would provide a broad scope of services. George Velmahos, MD, FACS, director, division of trauma, emergency surgery, and surgical critical care at Massachusetts General Hospital, Boston, noted that over the last several decades, trauma surgery has become a well-established specialty within general surgery. This subspecialty has spawned great advances in the care of severely injured patients. However, the increasingly nonoperative nature of trauma care, resident work-hour regulations, and lifestyle and job satisfaction issues may be making trauma surgery a less attractive career choice. At the same time, it is becoming increasingly difficult to recruit other surgical specialists to provide on-call trauma services. As a result, many complex specialty services are provided by residents, rather than fully trained surgeons. Dr. Velmahos described the trauma community’s proposal to combine trauma care with new emergency surgery services, such as treatment for bleeding, obstructions, perforations, and infections. Physicians providing this care would function as mem-

bers of dedicated in-hospital surgical teams to increase operative experience without compromising the care of injured patients.

Dr. Velmahos acknowledged that the development of this proposal faces many difficult challenges, including: the incorporation of specialties, such as orthopaedics and neurosurgery; defining “emergency” care; the impact on the “elective surgeon” workload; and methods to provide seamless coverage through interaction with non-surgical critical care teams. Nonetheless, he maintained that compelling evidence suggests that adequately trained trauma surgeons could safely provide high-quality acute emergency care, noting that in 2002, 57 percent of the operations performed by trauma surgeons were emergency procedures. He described the potential benefits of this new specialty in terms of improved care, research, finances, and quality control.

NEUROSURGERY’S PERSPECTIVE

Speaking on behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), Alex Valadka, MD, FACS, associate professor of neurosurgery at Baylor College of Medicine, stressed that neurosurgeons play a crucial, unique, and irreplaceable role in the treatment of patients with brain and spinal cord injuries. Central nervous system injury accounts for the majority of morbidity and mortality in trauma patients and for the largest share of trauma-related expenses. Dr. Valadka noted that in Scandinavia, non-neurosurgeons attempted to surgically treat intracranial bleeding with very poor results, concluding that it is better for patients to be transferred immediately to a neurosurgeon rather than receive care from other surgical specialists. He added that rapid stabilization and transport to a facility capable of providing definitive neurosurgical assessment and treatment are often pivotal factors in recovery.

Dr. Valadka explained that neurosurgery is the smallest of the three surgical specialties most involved in emergency care, with only 3,178 practicing board-certified surgeons (compared with 35,403 general surgeons and 22,711 orthopaedic surgeons). Furthermore, the overall workload for neurosurgery has increased. For example, the

number of elective cranial procedures increased 50 percent between 1988 and 2001. In addition, a survey of more than 1,000 AANS and CNS members showed that two-thirds of those individuals practicing at Level I or II trauma centers reported increases in the number of neurosurgery emergency cases in the past two years.

Neurosurgeons want to participate in their regional trauma systems but are finding it increasingly difficult to do so. They are unable to provide full-service emergency care and maintain a stable elective practice because of the elective surgery schedule and the amount of uncompensated care involved. Also, a concentration in neurosurgical emergency cases has persisted because of an inadequate number of neurosurgeons to provide 24/7 on-call coverage, the tendency of neurosurgeons in outlying hospitals to drop cranial and pediatric privileges, and the desire of at least some neurosurgeons at those institutions to eliminate emergency coverage altogether. Many neurosurgeons believe emergency care increases the likelihood of a liability claim. Hence, they have restricted their practices or moved to less litigious states. (More than one-third of 1,000 neurosurgeons surveyed report having been sued by a patient seen through their hospitals' emergency departments.)

The AANS and CNS further recommend the development of emergency neurosurgical care systems with external control over designation of regional centers and consideration of state-supported programs to designate trauma centers.

GENERAL CONCLUSIONS

A specialty workforce crisis is emerging, and it is affecting the emergency departments and trauma centers first. The problem is especially apparent in the increasing difficulty of finding surgeons to take emergency call, particularly in smaller specialties, such as neurosurgery and hand surgery.

The causes of the problem are varied and complex; therefore, their solutions will require careful thought. Simply producing more specialists will not be enough. In fact, for some specialties that solution is infeasible. Economic and environmental factors also must be addressed. Appeals to professional ethics won't solve the problem, because

the environmental stresses on emergency care are removed from ethics. Imposing unreasonable requirements on professionals in order to reconstruct systems that worked in the past won't work either.

More creative ideas, such as the ones that follow, are needed.

- Surgical and nonsurgical specialties, as well as other stakeholder groups, should collaborate to develop new systems of care.

- New systems that include more regionalization of emergency care need to be developed.

- Short-term solutions that make it more financially feasible for specialists to take emergency call, such as stipends, are acceptable but may be unsustainable over the long run.

- Legislative solutions to some of the contributing problems, such as the liability crisis, must be pursued.

- Increasing surgeons' understanding of EMTALA is essential. In addition, improving the profession's understanding of reimbursement rules pertaining to emergency care and advocating for rational policy changes is important.

- Medicare should create and fund additional training slots.

- The controversial notion of creating a surgical specialty dedicated to emergency care warrants further exploration.

- Public education and media relations campaigns could help to improve awareness of these issues and help promote the necessary changes.

The College and the surgical specialty groups will continue to work collaboratively to develop and promote policy solutions to ease the pressure on the nation's emergency care safety net. □