

A growing crisis in **PATIENT ACCESS** to emergency surgical care

by the Division of Advocacy and Health Policy

Editor's note:

On June 14, the Institute of Medicine held a press conference announcing the release of three reports on issues related to emergency and trauma care in the U.S. Concurrently, the College released the following report.

Drafted with input gathered at meetings with the surgical specialty societies, the College's report indicates that a growing patient population and stable supply of practicing surgeons are combining with other forces to produce workforce shortages, particularly in emergency departments and trauma centers. This report also documents some of the underlying causes of what the College views as an imminent workforce crisis, including declining reimbursement, the liability climate, trends toward subspecialization, lifestyle issues, and a lack of federal or state financial support for care provided to the uninsured. In this report, the College recommends short-term and long-term solutions to the building crisis.

Many changes have occurred in the surgical practice environment in the past two decades, but policy experts have given little scrutiny to the potential for unintended and undesirable effects. Even the rare policy research paper that notes how stresses in the system affect surgical patients tends to gloss over the implications of the situation. Surgeons in practice, however, have begun to take notice. While intermittent access and availability issues are becoming evident in many service areas and settings, one area raising deep concern universally is emergency care.

In March 2005 and March 2006, the American College of Surgeons hosted meetings with leaders of the surgical specialty societies to examine reports of a growing shortage of surgeons available to cover emergency departments (EDs) and trauma centers. In some specialties, the insufficient number of participants in emergency call panels has reached crisis proportions, and patients throughout the nation are feeling the impact. Furthermore, surgeons who remain in the emergency care system are experiencing professional and personal burdens that are simply unsustainable. The American Medical Association reached the same conclusions at meetings last fall and again in March of this year.

The situation is of such concern that several specialty organizations independently surveyed their members on this issue.* Despite the different survey populations, the findings were remarkably similar:

- A majority of surgeons take ED call five to 10 days a month; some surgical specialists take call far more often.
- Many surgeons provide on-call services simultaneously at two or more hospitals, and a significant number say they have difficulty negotiating their on-call schedules.
- Hospital bylaws typically require surgeons to participate in on-call panels, although older individuals are often allowed to “opt out,” and they are more frequently taking advantage of this option.

*American College of Surgeons, American Association of Neurological Surgeons, and American Society of Plastic Surgeons all conducted Web-based surveys either in 2005 or 2006.

- A significant number of surgeons have been sued by patients first seen in the ED, and some physicians are offered discounts on their liability coverage if they limit or eliminate ED call.

Despite earlier predictions, the number of surgeons trained through the nation’s graduate medical education system has not expanded for more than two decades. A growing patient population and a stable supply of practicing surgeons are combining with other forces to produce surgical workforce shortages, particularly in specialties with total workforce numbers in the hundreds or low thousands. Our nation’s trauma centers and EDs are feeling the most pervasive effects right now, although spot shortages are occurring in other settings and specialties as well.

The reasons for concern are clear. Patients need prompt access to definitive care when confronting a surgical emergency. But even more is at stake. Our nation’s EDs provide the one point of universal access to our health care system. They are the nation’s final safety net. Indeed, the public fully expects such access, and it is doubtful that patients realize it is eroding. Yet, policy experts and decision makers seem to be unaware of the trend, and certainly no focused efforts are under way to resolve the problem.

Equally important, our emergency care system (including the EDs, hospitals, trauma centers, and the health care professionals who compose it) forms the foundation of our nation’s response to future terrorist attacks and natural disasters. Emergency care capability has never been more important than it is in the post-9/11 world, and the need to strengthen it has never been more urgent.

The following information is an effort to document, based on the limited sources available, some of the underlying causes of this imminent crisis. Also included are proposed actions that should be explored immediately to begin addressing them. Clearly, much work remains to be done.

Overview of surgical care in the ED

According to the National Center for Health Statistics, approximately 114 million ED visits (39 per 100 people) took place in 2003, representing a 26 percent increase since 1993.¹ In

addition, nearly half of all hospital EDs reported that they were at or beyond capacity in 2005 and, as a result, were forced to divert ambulances to other facilities. The problem is particularly acute for teaching hospitals, which reported that 79 percent of their EDs were at or over capacity. Overcrowding is attributed to many factors—inpatient capacity and patient flow management among them—but frequently cited issues are the federal mandate to screen and stabilize all patients and a scarcity of on-call physicians and surgeons to provide specialty care.²

A variety of patient emergencies may require surgical care. Common reasons for surgical admissions involve: gallbladder disease; gastrointestinal bleeding; appendicitis; heart disease; aneurysm; stroke; and complications associated with procedures, devices, implants, or grafts. Patients suffering injuries from external forces, or trauma, most often require emergency surgical intervention. Trauma accounts for approximately 11.4 percent of nonpediatric and nonmaternity hospital admissions originating in the ED, according to the Agency for Healthcare Research and Quality.³

Formally designated trauma centers that function as part of a state or regional trauma care system are known to provide the highest-quality care to severely injured patients.⁴ Perhaps contrary to general assumptions, relatively few trauma center patients are victims of violence. According to the College's own National Trauma Data Bank® (NTDB®), victims of motor vehicle traffic accidents represent the largest segment of patients treated in our nation's trauma centers.⁵ Falls are the second most common cause of severe injury and are the most prevalent source of trauma in the elderly.

A March 2005 Harris interactive public opinion poll commissioned by the College's Committee on Trauma and the Coalition for American Trauma Care revealed that Americans appreciate the importance of prompt access to specialized trauma care services. Nearly all respondents recognized that it is extremely (63%) or very (31%) important to receive treatment at a trauma center in the event of a life-threatening injury. In fact, most respondents (eight out of 10) believed that having a trauma center nearby is of equal or greater value than a fire or police department.⁶

In addition, a significant majority indicated they would be extremely or very concerned to discover that their state's trauma system fell short of recognized standards of care. Unfortunately, a survey conducted by the Health Resources and Services Administration in 2002 found that only eight states met all the recognized criteria for a fully developed trauma care system, although 26 states met most criteria.⁷

Trauma systems provide an important means of ensuring access to emergency surgical care for the most severely injured patients. The trauma system model of regionalized care also holds promise for ensuring that patients receive treatment for other surgical emergencies, including those resulting from disasters. State or regional trauma systems are the bedrock for responding to disasters, whether natural or man-made, and policymakers have failed to support them with the vigor they show for other disaster preparedness and response programs.

The underlying problem: An emerging workforce crisis

A growing shortage of surgical specialists available to cover our nation's EDs is threatening access to prompt acute care services. While the science of forecasting physician supply and demand continues to evolve, it is apparent that previous predictions of an oversupply of specialists missed the mark. Conventional wisdom has shifted with the introduction of new peer-reviewed studies, and physician workforce analysts now project potential shortfalls in specialties that are crucial to community-based emergency care response.

Contrary to earlier assumptions, the number of surgeons trained in our nation's graduate medical education system has remained stable for more than 20 years (see Figure 1, page 11). As a result, U.S. population growth has outpaced the supply of surgeons. Furthermore, because the elderly comprise a disproportionate share of the surgical patient population, the "graying of America" is placing even greater demands on the supply of specialists.

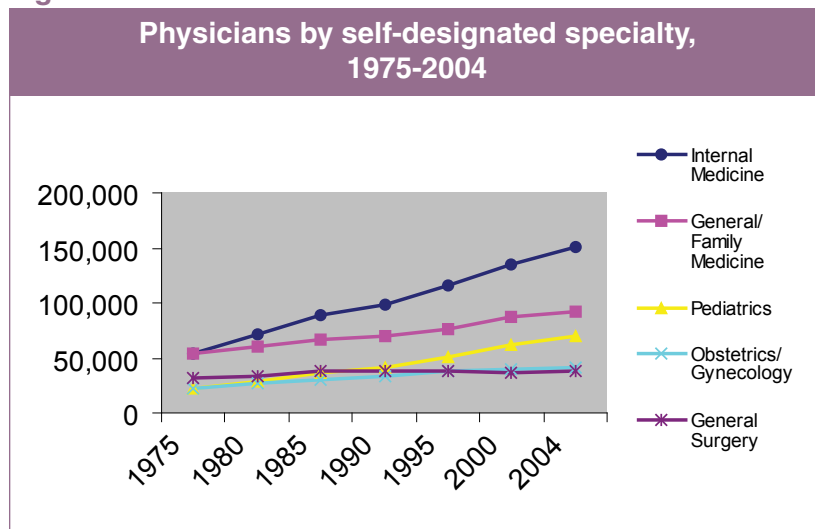
An analysis conducted by the Lewin Group of the American Hospital Association's ED and Hospital Capacity Survey of 2002 showed that neurosurgeons, orthopaedic surgeons, general

surgeons, and plastic surgeons were among the specialists in short supply for ED on-call panels.⁸ A similar survey conducted by the American College of Emergency Physicians in 2005 showed that nearly three-quarters of ED medical directors believe they have inadequate on-call specialist coverage, compared with two-thirds in 2004. In that survey, orthopaedic, plastic, and neurological surgeons, as well as otolaryngologists and hand surgeons, were reported as most often being in short supply.⁹ Using conservative estimates of U.S. population growth, it is apparent that the ratio of surgeons in these specialties available to provide emergency services that Americans will need is on the decline (see Figure 2, this page).

The problem is compounded by an aging surgical workforce, which makes fewer surgeons available for ED coverage due to decreased workload capacity and retirements. In many specialties that are key to ensuring adequate emergency call coverage, approximately one-third of the practicing surgeons are age 55 or older (see Figure 3, page 12). Contributing to this shortage are provisions in many hospital bylaws that allow older physicians to opt out of ED on-call responsibilities.

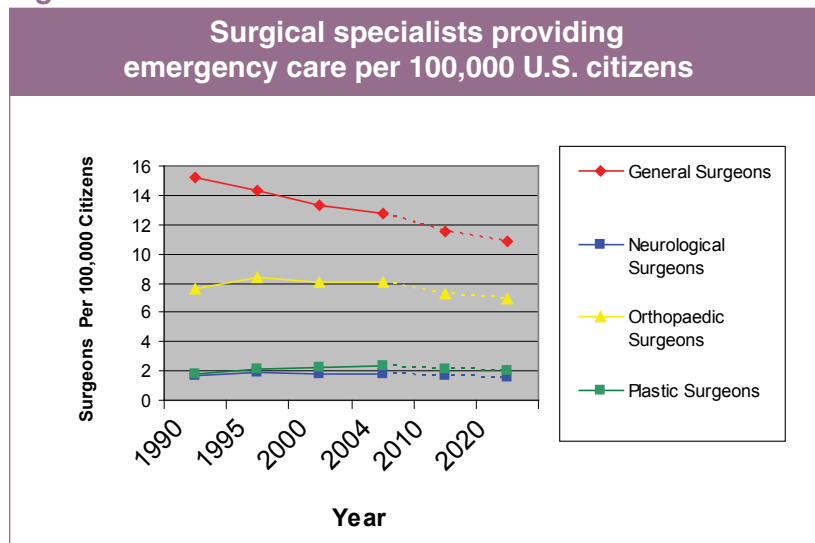
Workforce shortages exist across a range of medical disciplines but generally are far more significant for surgery. The workforce in nonsurgical specialties has grown steadily over time, while the number of individuals entering surgery each year has been relatively

Figure 1



Source: American Medical Association (AMA): *Physician Characteristics and Distribution in the US*, 2006 edition.

Figure 2



These data are for active surgeons, and the historical data were derived using figures from the AMA report, *Physician Characteristics and Distribution in the US*, 2006 edition, Tables 5.2 and 5.16. The projected data beyond 2004 assume a flat supply of surgeons from 2004 through 2020 and steady increases in the U.S. population to 325 million by 2010 and 345 million by 2020. These projected population figures are similar to those used by the Centers for Medicare & Medicaid Services, according to Richard A. Cooper, et al.¹⁰

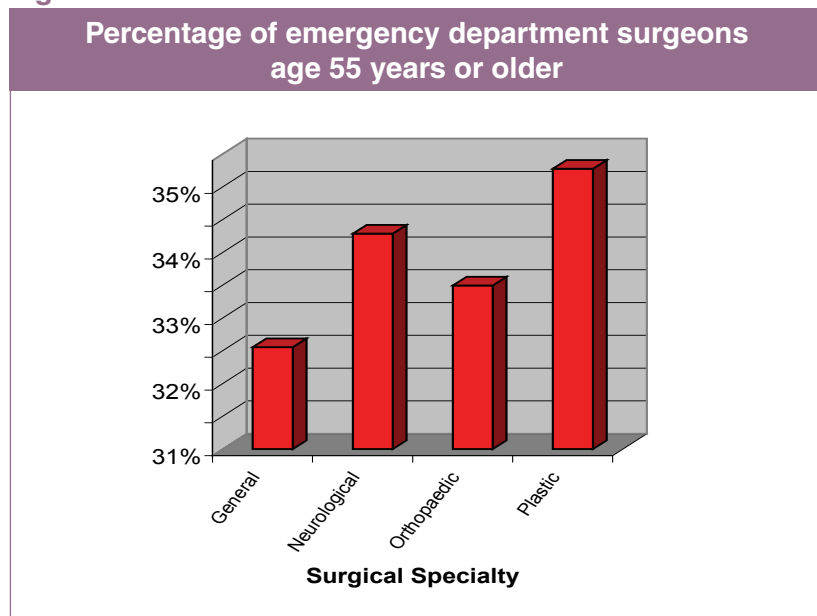
stable for more than two decades. In general surgery, for example, the rate of growth is not only slower than the growth in the general population, but it is significantly lower than the rate for nonsurgical specialties, including primary care specialties. (This statement is not intended to deny the genuine issues in other areas but to clarify that the problem in general surgery is far more acute and generally overlooked.)

Other professional trends add to the problem, including the growing movement toward specialization. Program directors, professors of surgery, and other individuals who are familiar with residency matches report that approximately half of all general surgery residents go on to pursue fellowships and subspecialization. As their scope of service becomes narrower, a new and alarming trend has emerged—many surgeons no longer feel qualified to manage the broad range of problems they are likely to encounter in an ED.¹¹ We can anticipate that, as hospital credentialing policies and state licensing requirements become more restrictive in coming

years, this issue will be of increasing concern. Furthermore, if additional research confirms suspicions that younger surgeons are inclined to narrow the focus of their practice, the implications are even more troubling as older surgeons begin to retire.

Another important but overlooked factor is the small number of specialists produced by training programs each year. As an example, approximately 130 neurosurgery residency training positions are offered each year, far fewer than the largest medical specialty, internal medicine, which offers more than 4,700 positions.¹² In addition, recent studies have found that the number of operative cases has generally and significantly decreased for all neurosurgery residents because of compliance with the 80-hour workweek restrictions.¹³ Considering the small number of neurosurgeons practicing in the U.S. today (approximately 3,200), the large portion of whom are older than age 55 (34%), and the time it takes to train a neurosurgeon (approximately seven years), it will be difficult to safely and adequately replace a shrinking pool of neurosurgeons participating in on-call panels.

Figure 3



These data are derived from the AMA report, *Physician Characteristics and Distribution in the US*, 2006 edition, Table 1.2.

The inadequate number of specialists providing emergency call services is taking its toll on quality of care. In a recent survey of ED administrators, 42 percent said that lack of specialty coverage in the ED poses a significant risk to patients. And, of those who indicated they would not choose their own ED as a source of care if they were seriously hurt (12%), an overwhelming majority (74%) listed the lack of specialty reinforcement as the reason.¹⁴

These workforce trends must be viewed within the context of rising demand for emergency services. Sharply accelerating need is chasing declining capacity, and the result is an emerging crisis in prompt access to emergency surgical care. In the short term, we need to develop

new ways to manage our surgical resources in order to meet current needs. In the long term, we need to better understand and address the underlying causes of these problems.

Short-term solutions

We must develop the means to make our current emergency care system work well, despite the pressing workforce shortage. The American College of Surgeons has a long history of originating programs to improve emergency care, and we are now applying these models to new efforts to make effective use of scarce health care system resources. Examples include the following:

- The College's publication *Resources for Optimal Care of the Injured Patient* outlines the resources hospitals must have in order to fulfill their commitment to trauma patient care at various levels. State and local authorities throughout the U.S. have used this guidebook as the foundation for trauma center designation. In addition, the College's Committee on Trauma provides hospital consultation visits at the request of hospitals, communities, or state authorities to assess trauma care and to verify trauma center compliance with these criteria. Similar programs are conducted in collaboration with the American Burn Association to define and assess the resources required for burn treatment centers.

- The College's *Trauma System Verification Program* provides a comprehensive, on-site trauma system review to help states and regions assess their organizational strengths and weaknesses in providing optimal care for injured patients beyond the walls of individual trauma centers. Following the Model Trauma Care System Plan that the Health Resources and Services Administration introduced in 1992, these reviews may be conducted at a multi-state, single-state, regional, county, or local level, depending on a particular system's scope and needs.

- The *Advanced Trauma Life Support® Program (ATLS®)* is a series of courses offered throughout the U.S. and abroad to provide an organized approach for the evaluation and management of seriously injured patients. Now in its 25th year, this program exposes both physicians

and physician extenders to proven methods of appropriately assessing and initially managing severely injured patients. The ATLS is the widely accepted "gold standard" educational program for inculcating all members of the trauma team in the common principles of emergency care and is applicable in both large urban centers and small rural EDs.

- More recently, the College initiated the *Rural Trauma Team Development Course* to help all members of the health care team provide the initial assessment and stabilization of severely injured patients. It is designed to integrate the trauma care team of a small rural hospital or clinic into a larger state or regional trauma care system, both to improve the efficiency of resource use and to ensure that injured patients receive the appropriate level of care.

The American College of Surgeons and other surgical specialty societies remain committed to developing new strategies for expanding access to urgent services. For example, we are achieving some consensus on how to apply the trauma system model so that a blueprint can be developed for better regionalizing specialty care services that may be required in an emergency situation. We believe this new structure would relieve EDs of the burden of being expected to cope with the broad range of potential surgical problems at all hours of the day and night. This strategy would be particularly appropriate for services provided by specialties with workforce numbers in the few hundreds or thousands, such as neurological and hand surgery.

In addition, the ATLS and Rural Trauma Team Development Course models could be applied to develop and implement protocols that allow physicians and surgeons in the ED to better assess whether conditions and injuries would best benefit from immediate, definitive specialty care or stabilization and treatment the following day, thereby lessening the demands on specialists on call.

Of course, the profession cannot address all of the contributing causes on its own; the federal government will need to intervene as well. Together, we can strengthen our nation's emergency care system. In the short term, we will work with Congress to reauthorize and appropriate funds for the Trauma Care Systems Planning

and Development Act, a program administered by the Health Resources and Services Administration that aims to ensure that state and regional systems of care are operating throughout the nation to provide prompt access to surgical care that severely injured patients need. We also will work with policymakers to help ensure that an emergency surgical workforce is identified and prepared to assist

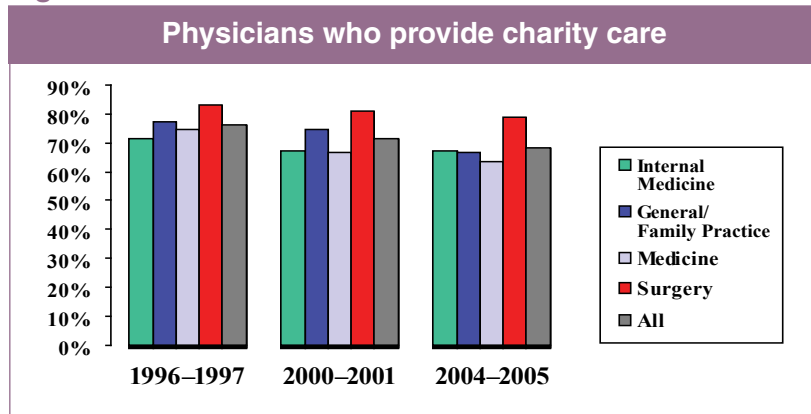
in the event of a national terrorist attack or natural disaster.

Forces shaping the workforce crisis

The single most important factor shaping the surgical workforce issue today is declining reimbursement. Physician concerns center not only on reimbursement for the emergency services themselves, which frequently are uncompensated, but also on insurance payments for procedures that comprise a major component of elective practice. These payments have been declining steadily over the past two decades. Related issues, such as the disruption that late-night emergency care causes to a surgeon's routine practice schedule and the lifestyle impact of frequent on-call service, undermine surgeons' willingness to take call.

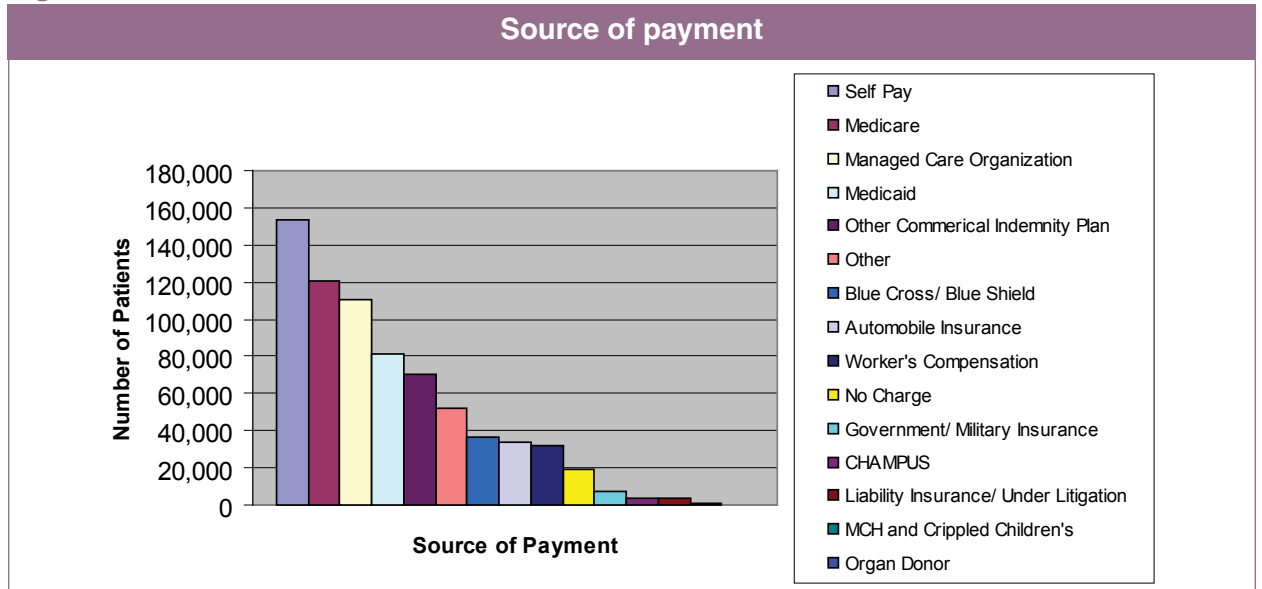
As a recent report from the Center for Studying Health

Figure 4



Source: Center for Studying Health System Change.¹⁵

Figure 5



Source: National Trauma Data Bank.⁵

System Change noted, surgical specialists are more likely than other specialists or primary care physicians to provide charity care, probably because of their emergency on-call responsibilities (see Figure 4, page 14).¹⁵ Yet, the number of both surgeons and other physicians who are providing charity care is decreasing, a trend the center attributes to declining practice incomes, which make it more difficult for physicians to subsidize unpaid care.

NTDB data confirm that surgeons bear the significant brunt of uncompensated care provided to severely injured patients.⁵ According to data compiled from more than 1.5 million patient records at 565 U.S. trauma centers, “self-pay” is the largest single payment category for trauma center patients (21%), followed by Medicare (17%), with Medicaid not far behind (11%) (see Figure 5, page 14). And, while hospitals may draw upon special federal and state financing streams to offset the costs of providing care to patients with little or no health insurance coverage, physicians and surgeons may not.

Furthermore, as Table 1 (right) illustrates, Medicare payments for many operations that elderly patients most often require are considerably lower than they were in the 1980s. These are actual, national average payment amounts, with no adjustment for inflation between 1989 and 2006. Payment levels for services frequently provided to injured patients in the ED have not fared much better, as shown in Table 2 (right). Because many private insurance plans and Medicaid programs use the Medicare physician fee schedule as the basis for their own payment arrangements, these trends are reflected throughout the health care system. Again, the overall decline in practice income makes it difficult for surgeons, most of whom are in solo and small group practices, to shoulder the burden of caring for patients who are unable to pay. According to information that the Centers for Medicare & Medicaid Services recently released, the Medicare reimbursement situation will only worsen as the sustainable growth rate system produces further across-the-board payment reductions, amounting to an additional 39 percent in the next nine years.¹⁶

All specialties have concerns about the Medicare payment system, but its flaws are especially problematic for surgical specialists. As Medicare

Table 1. Medicare payments for key operations (1989–2006)

Procedure	1989 average	2006 average	% change
Remove cataract	\$1,573	\$684	-57%
Total knee replacement	2,301	1,511	-34
Carotid endarterectomy	1,677	1,129	-33
Prostatectomy (TURP)	1,139	695	-39
Partial colectomy	1,256	1,226	-2
Laminectomy	2,078	1,051	-49
Hernia repair	560	469	-16
Coronary arteries bypass	3,957	2,049	-48
Mastectomy	1,051	997	-5

Table 2. Medicare payments for key emergency procedures (1990–2006)

Procedure	1990 average	2006 average	% change
Open treatment nose fracture	\$1,044	\$720	-31%
Open treatment eye socket fracture	888	714	-20
Open treatment humerus fracture	833	751	-10
Repair heart wound	1,203	1,129	-6
Repair ruptured abdominal aneurysm	2,535	2,243	-12
Burr hole for hematoma	1,526	1,087	-29
Craniotomy for hematoma	2,245	1,749	-22
Repair retinal detachment	2,760	1,375	-50

data show, medical services generally are growing at a rate that allows many specialists to offset per-service payment reductions by increasing service volume. However, the volume rates for surgical procedures are not growing—in fact, for many surgical services, volume is actually shrinking. So, not only are the overall payment cuts not offset, but, under the sustainable growth rate system, the increasing number of services provided by other physicians is actually *causing* the reductions.

Some surgeons are exhibiting market responses to these pressures, some of which affect access to emergency services. Certain surgeons have been forced to minimize financial disruptions to their practices by subspecializing in narrow fields dominated by elective services. In some cases, those surgeons who narrow their scope of services are able to omit hospital-based care from their practices, making them unavailable for emergency on-call panels. According to a survey conducted by the American College of Emergency Physicians, 51 percent of ED directors in 2005 reported deficiencies in on-call coverage because specialists left their hospitals to practice elsewhere.⁹ Hospital ED administrators report these specialists frequently relocate to ambulatory surgery centers (31%).¹⁴

In other cases, surgeons may eliminate risky or less profitable services from their practices. For example, a recent survey of neurosurgeons revealed that 38 percent now limit the types of procedures they perform. Of those, 57 percent have eliminated pediatrics, 13 percent no longer provide services related to trauma, and 11 percent no longer perform cranial procedures.¹⁷ For other surgical specialties with elective patients requiring hospital resources, one option has been to form their own specialty facilities equipped to provide only a limited range of nonemergency procedures.

Also affecting the availability of surgical care in EDs are liability issues unique to emergency care. Part of the growing reluctance to take call is because of a genuine concern that ED patients will sue. Surveys by the American College of Surgeons and the American Association of Neurological Surgeons/Congress of Neurological Surgeons revealed that more than one-third of respondents had been sued by a patient who was first seen in the hospital ED.¹⁸ A 2005 hospital ED administration survey also lists “malpractice concerns” as the principal factor discouraging specialists from providing ED coverage.¹⁴ Furthermore, because liability premiums have outpaced payments for their services, some surgeons have concluded that they simply cannot afford the added liability risk for a largely uninsured patient population.

In addition, younger surgeons, who often take the on-call shifts at trauma centers, are leaving states with the most severe liability problems.

For example, according to the Project on Medical Liability in Pennsylvania, funded by the Pew Charitable Trust, “Resident physicians in high-risk fields such as general surgery and emergency medicine named malpractice costs as the reason for leaving the state three times more often than any other factor.”¹⁹ Furthermore, an American Hospital Association study found that more than 50 percent of hospitals in medical liability crisis states now have trouble recruiting physicians, and 40 percent say the liability situation has resulted in less physician coverage for their EDs.²⁰ The crisis has even forced the closure of trauma centers in Florida, Mississippi, Nevada, Pennsylvania, and West Virginia at various times in recent years.²¹

Specialties that have experienced particularly high premium increases—including neurosurgery, orthopaedics, and general surgery—are also among those that provide services emergency patients most frequently require. According to a report from the General Accounting Office, soaring medical liability premiums have led specialists to reduce or stop on-call services to hospital EDs, seriously inhibiting patient access to emergency surgical services.²¹

Declining payments from all sources, a large burden of uncompensated care being provided in EDs, escalating practice overhead and medical liability premium costs, and new practice patterns that are causing some surgeons to narrow their breadth and limit in-hospital care are combining to produce an unfortunate result: the pool of surgical specialists from which to draft an emergency call schedule is being drained.

Long-term solutions

Many of the solutions the surgical profession has identified for these problems are enormous in scope and envelop the structure of our health care system and the interests of many stakeholders. Certainly, it is time for researchers and policymakers to begin addressing these difficult issues, bearing in mind that no stakeholder has more to lose than the surgical patient. Hence, it is time that surgeons and policymakers initiate changes that are currently feasible to address the underlying causes.

Federal and state laws do little to encourage surgical specialist participation in emergency on-call panels. The Emergency Medical Treatment and Labor Act (EMTALA), for example, was signed into law in 1986 as an effort to address the problem of patient-dumping by hospital EDs. The law grew both in scope and complexity for a number of years and was often interpreted in such a restrictive sense that it imposed untenable burdens on specialists providing emergency coverage. Although the federal government has taken steps to address some of the law's most serious weaknesses, specialists tend to view EMTALA as a mandate to provide uncompensated care around-the-clock, and the law is widely believed to be a primary factor behind practice behavior changes that are taking surgeons away from hospitals and EDs. In addition, the American College of Emergency Physicians noted in a recent report that EMTALA may actually encourage uninsured patients to seek ED care in increasing numbers because they are aware of the federal mandate to provide screening and stabilizing care.²²

The College pledges to work with regulators to continue refining laws such as EMTALA to remove disincentives for specialists to provide emergency care.

State insurance laws also unintentionally contribute to the problem of uncompensated trauma and emergency care. One such statute, known as the Uniform Accident and Sickness Policy Provision Law (UPPL), permits health insurers to deny coverage for trauma care for alcohol- or drug-related injury. The original intent of the UPPL was to free sober drivers from paying the medical bills of those who drive while intoxicated. However, the result is that surgeons receive no compensation for services provided to insured patients, who often require care in the middle of the night. Although a few states have repealed their UPPLs in recent years, most still have them on the books.

Indeed, it is important to remember that there are few mechanisms that can be used to provide compensation to surgeons and other specialists who care for the uninsured or patients who are covered by programs like Medicaid, which

traditionally provide low reimbursements. Unlike hospitals, surgeons do not have access to Medicare's "disproportionate share" payment program, and most states that collect funds for trauma and ED care through special driver's license fees, traffic violation fines, and so forth, funnel the money to institutions rather than to physicians.

A variety of mechanisms for improving the reimbursement issues that underlie the problem must be pursued. Of course, the federal government needs to take on the formidable task of comprehensively addressing the ever-growing number of Americans without health insurance. Moreover, the current Medicare payment system that is producing negative annual updates for all physician services, regardless of their unique value or spending trends, must be reformed.

The College will continue to work at the state level to eliminate UPPL laws that deny reimbursement for care provided to insured patients, as well as develop new strategies to provide physicians with access to the financing mechanisms available to facilities that provide uncompensated care.

At the federal level, we believe the government should support EMTALA's mandate that physicians provide care for the uninsured of emergency department patients by providing some tax relief for these services. Such a tax credit or deduction could be based on overhead costs as determined in the Medicare physician fee schedule. Alternatively, the government could adjust the practice expense "pools" it develops for each specialty in determining overhead costs in the Medicare fee schedule by taking into account the impact of uncompensated care on those costs, as it has for emergency medicine. Finally, we believe Medicare should support those hospitals that have resorted to paying stipends to ensure on-call coverage by recognizing these costs when determining changes in hospital market basket or updates under the prospective payment system, as it does for critical access hospitals.

To improve access in rural areas, where the surgical workforce problem is most acute, Medi-

care provides 5 percent bonus payments to physicians who practice in physician scarcity areas. Unfortunately, the program appears to work better for primary care physicians than for specialists, largely because bonus payments are based on the location where services are rendered. Surgeons who care for sparse populations tend to provide their services either in regional hospitals or office buildings near those institutions. As a result, the actual site of service may be outside a physician scarcity area, even though the vast majority of the population being served resides in such an area. Another program provides 10 percent bonuses to physicians who render services in health professional shortage areas, but that program applies only to primary care and mental health providers.

Similarly, federal programs geared toward recruiting more physicians to provide care in underserved areas tend to favor primary care and certain nonphysician providers. The National Health Service Corps, for example, provides scholarships and medical school loan repayments to health professions students in return for a period of service in an urban or rural health professional shortage area. Again, no such program is available to surgeons and other specialists.

We will work with Congress to create a health professions support program to cover medical school debt for young surgeons providing surgical care in community or rural hospitals/trauma centers. We also will work with policymakers to refine current laws pertaining to physician scarcity areas so they may more effectively encourage surgical specialists to provide care in areas where demand is greatest.

Even federal programs providing limited medical liability protections for volunteer physicians tend to favor office-based care rather than treatment for the uninsured in the nation's EDs. The Volunteer Protection Act, for example, applies only to individuals serving in not-for-profit organizations. In addition, Public Health Service Act section 224 provides Federal Tort Claims Act protection for services provided to patients of community health centers. However, because the focus is on community health cen-

ters, these protections only apply to primary care and office-based services. Surgeons who provide care to patients referred by community health centers receive no protections under the statute.

All medical and surgical specialty organizations support enactment of comprehensive, common sense, medical liability reforms. Until a comprehensive and nationwide solution emerges, however, interim steps addressing the most immediate concerns should be considered. For example, policymakers can limit exposure to medical litigation and provide qualified immunity for EMTALA care by bringing these mandated services under the Federal Tort Claims Act. Similar strategies may be pursued on the state level.

One federal program intended to ensure prompt access to surgical care for severely injured patients was established in the Trauma Care Systems Planning and Development Act of 1990 mentioned previously. Administered through the Health Resources and Services Administration, in the past several years this program has distributed \$31.4 million in funds to all 50 states and five territories for the purpose of developing state and regional trauma care systems. But today, even with this influx of federal funds, the nation's trauma systems remain incomplete, and, unfortunately, only one-fourth of the U.S. population lives in an area served by a trauma care system.²³ Furthermore, efforts to reauthorize the program failed in 2005, no funds were appropriated for 2006, and the President's fiscal year 2007 budget proposes its elimination—all despite the fact that in 1999 the Institute of Medicine called on Congress to “support a greater national commitment to, and support of, trauma care systems at the federal, state, and local levels.”²⁴

In addition to advocating the reauthorization of the Trauma Care Systems Planning and Development Act, we will work with policymakers in the future to expand this concept to other surgical emergencies, including those resulting from natural or man-made disasters. We also will explore improvements in

telemedicine to facilitate specialist consultations across state lines.

Finally, it is vitally important that policy researchers and policymakers gain a greater understanding of the forces that are undermining our nation's emergency care system. Studies of the growing uninsured population, for example, must expand their focus beyond the important but narrow issue of chronic disease management and begin considering the implications for access to high-quality acute care services for all Americans. The American College of Surgeons is committed to initiating this dialogue and will continue its collaboration with representatives of all surgical specialties to improve our understanding of the problems confronting surgical practice today and to develop innovative solutions to resolve them. □

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