As an aging population, a recovering economy, and health care reform bring more patients into the operating room, will there be enough surgeons to care for them? A shortage of 124,000 to 159,000 MDs is projected within 15 years—and about a third of the shortage will be in surgery, according to the Association of American Medical Colleges (AAMC).

Every surgical specialty has fewer surgeons entering practice than 20 years ago. And over a third of surgeons are over age 55, AAMC reports. The surgeon workforce is facing a “perfect storm,” says George Sheldon, MD, FACS, who points out there are fewer surgeons per population than 50 years ago. He is director of the American College of Surgeons Health Care Policy Research Institute at the University of North Carolina, Chapel Hill.

General surgery has been particularly hard hit. The ratio of general surgeons to the population has declined by 25% in the past 25 years. For rural areas, it’s a crisis, according to the National Rural Health Association:

• Rural areas have only half as many surgeons per capita as cities.
• More than half of general surgeons in rural areas are over age 50.
• Of about 211,000 physicians in rural America, about 9,300 are general surgeons.

Who will do joint surgery?

Key specialties are affected.

Only 70 physicians entered cardiac surgical residencies in 2009. “Cardiothoracic disease is still going to be the number one killer. Who is going to do those surgeries?” Dr Sheldon asks.

Patients with ailing joints in the coming years could have trouble finding an orthopedic surgeon, two researchers say.

By 2016, if trends continue, 46% of hip replacements and 72% of knee replacements needed won’t be able to be performed because there won’t be enough orthopedic surgeons, Thomas K. Fehring, MD, reported in a study presented at the 2009 American Academy of Orthopaedic Surgeons meeting. Another study by Steven M. Kurtz, PhD, found demand for the surgery is expected to double in the next 10 years, spurred primarily by demand from younger patients.

Both said policy makers need to look at reimbursement for joint replacements, which has continued to go down while costs go up.

Fueling the storm

Two major forces have fueled the “perfect storm,” Dr Sheldon says. The first was a report issued in 1981 that projected a surplus of 145,000 physicians by 2000. In the 1990s, another report predicted managed care would shift demand toward primary care, and there would be too many special-
ists. As a result, medical schools quit expanding, while the population kept on growing.

The second was the Balanced Budget Act of 1997, which froze graduate medical education funding and thus residency positions. A number of other studies have had conflicting findings.

Dr. Sheldon cites one figure he thinks is telling: “In 1981, we graduated 1,047 people who became certified in general surgery. Last year (in 2008), it was 1,032. The country has grown by 25 million people since 1980.

“The bottom line is we’re behind in creating a sufficient workforce in almost all surgical fields.” Though some residency slots have been added since 1997, it’s “not nearly enough,” he says.

Other forces contributing to the dwindling supply of surgeons were traced by Thomas R. Russell, MD, FACS, in a 2007 report:

- declining reimbursement
- liability concerns
- declining interest in critical specialties like general surgery and neurosurgery, as physicians gravitate to subspecialties that perform more elective procedures.

**Medical schools ramping up**

One storm condition is starting to clear up. More medical schools are opening and producing more physicians. About 2 dozen new medical schools have opened or might open across the country, the most at any time since the 1960s and 70s, *The New York Times* reported (February 15, 2010).

But limits on residency programs haven’t been addressed.

“If we don’t do anything about residency programs, it won’t do any good—there won’t be any residency slots for them to fill,” Dr. Sheldon says.

**Would adding physicians help?**

Others say efforts need to reach beyond producing more physicians and surgeons.

Asked whether there will be a shortage of general surgeons or specialists, “I think is the wrong question,” says David Goodman, MD, MS, director of Dartmouth’s Center for Health Policy Research in Lebanon, New Hampshire, who has studied the physician workforce for 20 years.

Instead, he says the question should be: What will provide access to better care that improves the outcomes of patient populations?

Spending resources just to add physicians “doesn’t help very much,” he says. That’s because physicians tend to migrate to higher-income communities, while rural communities and lower-income areas have a tough time attracting practitioners.

“We have learned in our research that for every physician who goes into a low-supply area, 4 physicians go into an area that already has a very high supply,” Dr. Goodman says.

For this reason, he says, there hasn’t been much acceptance among policy makers in “turning on the training tap. It’s not just the training costs. It’s the fact that most of those physicians go to places where utilization is already high, and they are generating a lot of expensive care.”

**What would help?**

Policy changes might help encourage more practitioners to go to areas where they are needed, Dr. Goodman suggests. Some are included in the health care reform package.
• More support for the National Health Service Corps and other subsidies for physicians who serve underserved populations. Under the health care reform package, general surgeons working in shortage areas will receive 10% additional reimbursement for major surgery from 2011 through 2015.
• More integrated health care systems that would use practitioners more efficiently.
• Decision aids to assist patients in making informed choices. Examples are videos and other tools to help a patient with a herniated disc decide on the best treatment. Dartmouth has fostered this concept of shared decision making. Language to encourage development of patient decision aids is in the reform law.
• A permanent health care workforce commission to develop policies at the national level, which is included in the reform law.

To attract general surgeons to rural areas, the National Rural Health Association advocates enhanced fee schedule payments in rural areas and tax incentives for surgeons who locate in rural areas.

Technology might also help. The federal government is providing grants for telemedicine in rural communities, which might relieve the professional isolation rural physicians may feel.

Greater role for nurses

Dr Sheldon sees physician assistants and advanced practice nurses as one way to augment the surgeon workforce. At the University of North Carolina, where he is professor of surgery and social medicine, advanced practice nurses are employed in specialties such as transplantation, cardiac care, and trauma. Similar models can be applied in primary care and other specialties, he adds. By some estimates, 80% of care for older patients is for chronic conditions.

“There is no reason why you can’t get into a pattern where much of that care is being given by advanced practice nurses,” he says. 

—Pat Patterson

References


