



Statement  
of the  
American College of Surgeons

Committee on Finance  
United States Senate

**Workforce Issues in Health Care Reform:  
Assessing the Present and Preparing for the Future**

March 12, 2009

The American College of Surgeons (ACS) commends Chairman Baucus and the Senate Committee on Finance for holding this important hearing on “Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future.” On behalf of its more than 74,000 members, the ACS is grateful for this opportunity to present a statement describing the surgical workforce challenges facing our nation.

While many raise concerns about the adequacy of the nation’s primary care workforce, it is important to note that the primary and preventive care these physicians provide is but one component of our nation’s health delivery system, and, though important, primary care is not alone among physician specialties in facing a workforce shortage to meet the needs of patients. The ACS and others have continued to warn that the nation’s health care workforce challenges extend beyond primary care, and we are already seeing signs of an emerging national crisis in patient access to surgical care. In conversations with Congressional leaders and their staff members, the ACS is also increasingly hearing how a growing number of hospitals in Senators’ and Representatives’ home states and districts are struggling to keep and find surgeons to care for their constituents.

### ***The Problem—An Emerging Crisis***

One of the areas where the ACS has seen this crisis emerging most rapidly and most acutely is among our nation’s general surgery workforce. General surgeons are specifically trained to provide comprehensive surgical care, and because their expertise is broad, they are qualified to manage a wide variety of medical conditions, ranging from oncology to gastrointestinal maladies, from endocrine surgery to ruptured aneurysms, and from hypertension to breast surgery. When patients require complex, multi-system care, a general surgeon can fill the gap between other physician specialties. In the case of major trauma, general surgeons are frequently on the frontlines of emergency care, saving lives on a daily basis. Think of it this way: If primary care is the medical home, then general surgeons are the first responders when that home is on fire.

Last April, the *Archives of Surgery* published an analysis of the trends of the general surgery workforce between 1981 and 2005. The analysis showed that the number of general surgeons as a proportion of the population declined by over 25 percent during that 25 year period. Even though the American population grew by more than 60 million people between 1981 and 2005, the number of general surgeons actually declined by 4.2 percent over the same time span. While this decline was felt in both rural and urban areas, rural areas continued to have significantly fewer general surgeons per capita than their urban counterparts. In addition, whereas in 1981, of the general surgeons practicing in rural areas, only 39 percent were between the ages of 50 and 62; now over 50 percent are between the ages of 50 and 62. Further complicating the outlook for general surgical care, the *Archives* study showed that while the number of general surgical residents has remained fairly static at approximately 1,000 per year since 1980, increasing numbers of general surgical residents are specializing. Whereas in 1992, a little over half of all general surgery residents entered a fellowship, now over 70 percent

of all general surgery residents choose to pursue a fellowship. Some may question what effect increased specialization, sub-specialization, and the development of new technologies and treatments has had on the number of general surgeons in the United States, but the *Archives* article pointed out that there is no evidence showing a relationship between these developments and the number of general surgeons.

In addition, other research shows that general surgery is not alone among surgical specialties facing significant workforce challenges at present and in the years ahead. The Dartmouth Atlas has compiled similar findings not only in general surgery but in other surgical specialties as well. Dartmouth data showed a 16.3 percent decline in the per capita number of general surgeons between 1996 and 2006 as well as per capita declines of 12 percent, 11.4 percent, and 7.1 percent in urology, ophthalmology, and orthopaedic surgery, respectively. Further, the Bureau of Health Professions projects an increase of only 3 percent among practicing surgeons between 2005 and 2020—with projected declines in thoracic surgery (-15%), urology (-9%), general surgery (-7%), plastic surgery (-6%), and ophthalmology (-1%). Over the same time period, BHP projects that the number of practicing primary care physicians will increase by 19 percent.

### ***Implications for Patients***

Needless to say, the data shows that this is not simply an anecdotal problem, but rather one with implications for all Americans in urban, suburban, rural and frontier areas. The implications of the trends are felt most significantly in local hospitals, particularly in rural and lesser populated areas. In an April 8, 2008 article in the *Billings Gazette*, Charles Rinker, MD, FACS, a general surgeon from Bozeman, Montana, highlighted how Livingston, Montana, a town that had three general surgeons in 1976 was now fortunate to still have one. He also highlighted the case of another general surgeon who after being on call every day and night over 16 years finally moved from Butte, Montana to Tacoma, Washington so he could spend more time with his family.

In the March 21, 2008 edition of the *Des Moines Register*, Thomas Foley, MD, FACS, a general surgeon in Marshalltown, Iowa, discussed similar problems facing his state, pointing out that of the 28 Iowa communities looking for general surgeons, over half had populations of 10,000 or less. In Arkansas, between 1997 and 2004, twelve counties saw a decline in the number of practicing general surgeons, and seven Arkansas counties lost all of their general surgeons. In those seven counties, five hospitals significantly reduced their services and two had to close their doors.

These trends just described are not confined to these states but illustrative of problems seen across the country. Further evidence of these trends is included in the chart attached to the end of this testimony. Regardless, the trends in these states have implications not just for their citizens, but for the millions of Americans who visit and travel through these states as well. In spite of all the technological advances in medicine, it is almost hard to fathom that whether or not someone survives or dies in an automobile accident may well be determined by the state and locale of where that

accident occurs, but that is the present situation posed by our nation's surgical workforce challenges.

### ***Surgery's Unique Challenges***

The long-term outlook for the future of surgery contributes to fewer medical students and residents choosing surgery as a specialty. Unlike many other medical specialties, there are no good substitutes or physician extenders for a well-trained general surgeon or surgical specialist when it comes to trauma care or surgical emergencies. Surgical training is vastly different from other physician training programs. Mastery in surgery requires extensive and immersive experiences that extend over a substantial period of time. Whereas non-surgical residencies can be completed in as few as three years, surgical residencies require a minimum of five years and often several more for specialties such as cardiothoracic surgery. Of course, the rigor of a surgical residency is certainly not for everyone: the work hours, sleep cycles, and intensity fit a surgical resident's personality much in the same way dermatology, internal medicine or pediatrics fits another. However, the prospects of declining payment coupled with rising practice costs; increasing liability premiums and the escalating threat of being sued; a crippled workforce leading to more on-call time, higher caseloads, and less time for patient care; and an uncertain future for the U.S. health care system understandably deter would-be surgeons from making the extra sacrifices necessary to become a surgeon.

The decrease in the numbers of general surgeons most directly impacts the 54 million Americans who are cared for in small and rural hospitals. While some of the rural workforce challenges relate directly to the difficulty in recruiting surgeons to those areas, some are also the result of a lack of workforce reinforcement. For instance, the level of on-call time is greatest in rural areas; as in the case of the Montana surgeon, some general surgeons are forced to take call 24 hours a day, 7 days a week. Needless to say, after spending several intensive years in residency, such a requirement may not, understandably, be an attractive one for a surgeon who has likely already sacrificed several years of family time during training. In addition, older surgeons in rural areas know that retirement or a less stringent workload may be further off than planned. Surgeons in rural areas also have a lower day-to-day volume of the types of procedures they are expected to perform at any given moment, making them less confident about the quality of care they will be able to provide and adding to liability concerns. For those who stay in rural areas, these issues are of great worry, and many surgeons are choosing to leave rural areas for the relative professional security of a more populated place to practice.

### ***Solutions—Preserving and Improving Access to Surgical Care***

The ACS has developed several proposed measures and would be open to other solutions that improve patient access to surgical care and ensure the needed surgical workforce in the future. To that end, it is important to support the residency programs that already exist and to promote the development of additional residency programs as

well, particularly in rural areas. In addition, it is important to develop appropriate supports and incentives for medical students who are interested in pursuing a surgical career while also, as much as is possible, eliminating the disincentives that push medical students away from the surgical profession. To this end, the ACS would encourage the Committee to strongly consider the following policy options:

- Preserve Medicare funding for graduate medical education (GME) and eliminate the residency funding caps.
- Fully fund residency programs through at least the initial board eligibility.
- Include surgeons under the Title VII health professions programs, including the National Health Service Corps (NHSC) program, making them eligible for scholarships and loan assistance in return for commitment to generalist practice following training.
- Alleviate the burden of medical school debt and promote rural/underserved care through loan forgiveness programs that stipulate work in rural/underserved areas.
- Extend medical school loan deferment to the full length of residency training for surgeons.
- Allow young surgeons who qualify for the Economic Hardship Deferment to utilize this option beyond the current limit of three years into residency.
- Increase the aggregate combined Stafford loan limit for health professions students.

The College also supports legislation that seeks to increase the number of residency training programs. At present, a majority of residency training programs exist in or near major metropolitan cities. While the current programs continue to excel at producing high quality surgeons, they do not adequately distribute surgeons to communities across the nation. A major obstacle often preventing the establishment of new residency training programs are the costs associated with the creation of such programs. The Physician Workforce and Graduate Medical Education Enhancement Act (H.R. 914), which was introduced by Representative Michael Burgess, MD (R-TX) and Representative Gene Green (D-TX), would establish an interest-free loan program where hospitals committed to starting new residency training programs in one or a combination of seven medical specialties, including general surgery, could secure start-up funding to offset the initial costs of starting such programs. By providing a greater number of residency training programs in previously underserved areas, the surgical workforce shortage could be reduced for many states. In addition to the measures previously discussed, the ACS believes this legislation would be an appropriate step toward addressing the workforce challenges we are witnessing in rural areas. The ACS will continue to support this and other legislation that helps ensure patient access to surgical care.

Surgeons complete their training and enter their profession with full knowledge that certain requirements will be made upon their time and family life, and this includes serving on on-call panels for emergency and trauma care situations. Yet, as has been already noted, there are structures and disincentives within our current health care

system that complicate this task and complicate surgeons' ability to provide the emergency and on-call services on which all Americans depend. In addition, these on-call responsibilities can be particularly significant in rural and lesser populated areas, further complicating efforts to recruit surgeons to these areas. To support these surgeons' commitment to provide emergency surgical care, particularly in rural areas, and to help avert an emergency surgical workforce crisis, the ACS encourages the Committee to consider the following measures:

- Include surgeons in bonus payment structures for health professional shortage areas.
- Allow surgeons access to Medicare's disproportionate share program, currently restricted to hospitals, when they operate on patients they see in the emergency department (ED) or as a result of care provided under the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA).
- Provide tax relief to surgeons who perform EMTALA-related care. This could be based on overhead costs as related to the Medicare physician fee schedule.
- Adjust Medicare practice expense pools for each specialty to account for uncompensated care related to ED or EMTALA-related care as is done for emergency medicine.
- When hospitals pay stipends to surgeons who take emergency call, Medicare should recognize these costs as is currently done for critical access hospitals.
- Provide liability reform for surgeons who perform EMTALA-related care.
- Expand the Federal Tort Claims Act to include surgeons who provide services to patients who are referred through their primary care physician at a community health center.

Finally, the most immediate challenge for patient access to surgical care is the precarious reimbursement situation confronting surgeons and surgical practices. As the Committee is well aware, Medicare payments to physicians will be cut 21.5 percent on January 1, 2010 if Congress does not act. The ACS calls on this Committee and Congress to take action to stop this cut, to provide an increase in Medicare payments for all physicians in 2010, and to initiate reform for Medicare's physician payment system this year. The ACS greatly appreciated the leadership of Chairman Baucus and the bipartisan work of this Committee to enact the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) last July that reversed the 10.6 percent cut in Medicare physician payments. In addition, MIPPA included the largest Medicare payment increase for physicians since 2005 by replacing a scheduled 5.4 percent cut in 2009 with a 1.1 percent increase this past January. MIPPA also made changes to how work was valued under the Relative Value Scale, increasing payments for some surgical services. In spite of these important measures, Medicare payments for many surgical procedures have been reduced significantly over the past twenty years and, in some cases, they have been cut by more than half from reimbursement levels in the late 1980's. In spite of these payment trends and the workforce challenges just outlined, some, most notably the Medicare Payment Advisory Commission (MedPAC), have proposed financing increased reimbursement for primary care by simply cutting reimbursement for care provided by other physician specialties. Such proposals, while

seeking to promote efforts to help Americans better manage their care, would further exacerbate the workforce challenges previously described and ironically establish a reimbursement structure that would ultimately undermine patients' ability to access the life-saving acute care services that only surgeons are qualified to provide. After all, increasing Americans' access to health insurance coverage will have little value if Americans cannot obtain the care they need from the appropriate physician. As a result, it is critical that Congress take steps now to ensure a stable surgical and a stable physician workforce for all Americans for years to come. The ACS supports efforts to prevent disease and to manage patient care not only because it is in the best interests of the patient and health care system but also because, when these patients need surgery, they are much less likely to encounter complications and much more likely to recover quickly from the operation. However, regardless of how well patients' care is managed, acute situations requiring prompt and definitive access to surgical care will continue to occur.

The ACS is grateful for the opportunity to provide a statement regarding these important challenges facing our nation's surgical workforce. The ACS remains committed to enacting reforms of Medicare's payment system that preserve and further patient access to surgical care and to the range of important services provided by our colleagues in medicine. The ACS looks forward to working with this Committee to avert this cut and to initiate the much needed reform of Medicare's payment system this year. The American College of Surgeons stands ready to work with Chairman Baucus, Ranking Member Grassley and all members of this Committee to ensure that all Americans will continue have access to the comprehensive health care services that America's surgeons and physicians provide.

### 1996-2006 Percentage Change for Physicians Per 100,000 Residents\*

State	Total Physicians	Cardiologists	General Surgeons	Neurosurgeons	Ophthalmologists	Orthopaedic Surgeons	Urologists	Primary Care
AZ	<b>-0.10%</b>	9.69%	<b>-19.67%</b>	<b>-23.14%</b>	<b>-28.93%</b>	<b>-26.48%</b>	<b>-7.20%</b>	1.82%
AR	10.24%	20.48%	<b>-8.64%</b>	43.69%	<b>-12.09%</b>	<b>-9.40%</b>	<b>-19.21%</b>	9.80%
DE	16.19%	28.71%	<b>-13.85%</b>	<b>-28.34%</b>	<b>-17.41%</b>	3.05%	<b>-11.01%</b>	16.92%
FL	5.30%	8.19%	<b>-24.43%</b>	<b>-11.43%</b>	<b>-14.92%</b>	<b>-21.38%</b>	<b>-14.26%</b>	9.45%
ID	18.82%	57.17%	<b>-8.09%</b>	<b>-12.27%</b>	<b>-12.79%</b>	12.49%	5.30%	29.66%
IA	15.30%	45.30%	<b>-12.65%</b>	0.60%	<b>-12.26%</b>	<b>-4.18%</b>	<b>-1.75%</b>	19.70%
KS	9.59%	49.43%	<b>-7.49%</b>	15.29%	12.21%	4.95%	<b>-6.26%</b>	16.71%
KY	12.51%	35.45%	<b>-23.59%</b>	<b>-21.17%</b>	<b>-4.16%</b>	<b>-7.76%</b>	<b>-8.88%</b>	13.94%
ME	24.84%	10.32%	2.99%	<b>-5.46%</b>	<b>-8.05%</b>	<b>-6.27%</b>	10.71%	37.72%
MA	6.82%	<b>-2.72%</b>	<b>-23.72%</b>	<b>-18.71%</b>	<b>-6.76%</b>	<b>-15.29%</b>	<b>-15.81%</b>	12.41%
MI	8.83%	<b>-2.40%</b>	<b>-22.04%</b>	12.47%	<b>-12.22%</b>	<b>-11.76%</b>	<b>-16.91%</b>	14.42%
MT	12.33%	<b>-3.54%</b>	<b>-15.18%</b>	<b>-13.49%</b>	<b>-20.92%</b>	11.03%	4.09%	19.00%
NJ	<b>-4.08%</b>	<b>-3.25%</b>	<b>-33.32%</b>	<b>-6.56%</b>	<b>-18.77%</b>	<b>-16.15%</b>	<b>-13.39%</b>	<b>-7.61%</b>
NV	8.91%	0.63%	<b>-27.77%</b>	<b>-5.66%</b>	<b>-18.70%</b>	<b>-2.96%</b>	<b>-13.80%</b>	15.77%
NM	10.50%	17.53%	<b>-14.02%</b>	<b>-32.17%</b>	<b>-25.55%</b>	<b>-20.14%</b>	<b>-22.15%</b>	16.42%
NY	4.21%	10.95%	<b>-25.37%</b>	<b>-0.28%</b>	<b>-12.46%</b>	<b>-9.40%</b>	<b>-14.61%</b>	8.00%
ND	15.17%	22.78%	<b>-11.73%</b>	<b>-21.30%</b>	<b>-16.08%</b>	9.70%	<b>-12.04%</b>	17.26%
OR	17.97%	25.34%	<b>-0.20%</b>	<b>-5.38%</b>	<b>-6.67%</b>	<b>-5.74%</b>	<b>-8.37%</b>	25.78%
TX	9.14%	30.84%	<b>-18.86%</b>	4.60%	<b>-9.65%</b>	<b>-5.52%</b>	<b>-7.51%</b>	11.37%
UT	16.74%	23.33%	<b>-1.01%</b>	11.46%	5.78%	<b>-8.45%</b>	<b>-12.21%</b>	28.12%
WA	14.69%	15.32%	1.04%	<b>-19.28%</b>	<b>-12.88%</b>	<b>-7.33%</b>	<b>-6.86%</b>	23.01%
WV	13.13%	11.08%	<b>-12.05%</b>	6.23%	<b>-2.79%</b>	<b>-4.47%</b>	<b>-24.09%</b>	16.19%
WY	21.65%	35.08%	8.12%	89.71%	6.04%	37.26%	<b>-9.92%</b>	14.53%
<b>National Percentage</b>	<b>10.33%</b>	<b>14.44%</b>	<b>-16.31%</b>	<b>-0.46%</b>	<b>-11.43%</b>	<b>-7.08%</b>	<b>-12.01%</b>	<b>14.35%</b>

\*100,000 per Hospital Referral Regions, which is defined by documenting where patients were referred for major cardiovascular surgical procedures and neurosurgery in their respective states.

\*All Physician data obtained from the Dartmouth Atlas of Health Care Database