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How Salary and Reimbursement Impact Physician Workforce

THE LOOMING SHORTAGE OF GENERAL SURGEONS

Our presidential election is only days away. 48 million people in America are uninsured and healthcare costs are rising two to three times faster than our nation's GDP. Where will America's healthcare system be in five years? Welcome to ReachMD's monthly series focus on public health policy. This month we explore the many questions facing healthcare today.

Could general surgery be a dying art, does reimbursement have anything to do with it? You are listening to ReachMD XM 157, the channel for medical professionals. Welcome to the Clinician's Roundtable.

HOST:

Bill Ruttenberg, M.D.

GUEST:

Dr. George Sheldon.

I am Dr. Bill Ruttenberg, your host, and with me today is Dr. George Sheldon. Dr. Sheldon is a Professor of Surgery at the University of North Carolina, Chapel Hill, and chaired the Department of Surgery from 1984 until 2001. He has been president of all the major surgical organizations including President of the American College of Surgeons, President of the American Surgical Association and the American Board of Surgery. Dr. Sheldon is currently editor-in-chief of www.e-facs.org, the web portal of the American College of Surgeons and is Director of the Health Policy Institute of the American College of Surgeons. Today, we are discussing the impact of reimbursement on physician shortages.

Dr. RUTTENBERG:

Welcome Dr. Sheldon, thanks for joining us at the Clinician's Roundtable.

Dr. SHELDON:

My pleasure.

Dr. RUTTENBERG:

In a recent commentary, "The Impending Disappearance of The General Surgeon" which appeared in the Journal of the American Medical Association, Dr. Joseph Fisher wrote "surveys of surgeons indicate that the single most important factor in deciding on early retirement, practice restriction, and career change is the unfavorable work environment. The environment has been fostered primarily by commoditization of medicine, which includes reimbursement manage care with its ever changing rules and professional liability. Dr. Sheldon, how do you feel about what Dr. Fisher has written?

Dr. SHELDON:

Dr. Fisher is a very close friend of mine and in fact he acknowledges some of our conversations in that article at the end. I think he is right on all of it, obviously that's a focused article and I think there are other things involved in the issue of the shortage, but I think those are all important. He has been a careful student of reimbursement cycle for many, many years and he is very familiar with it. I think the methodology _____ started, general surgeons were not part of that initial panel. The resource based relative value scale has been a problem ever since it started. I think this was added to a great deal by the Balance Budget Act that assumed that we would save money by putting a freeze on it. Frankly, doctors are not as good with business as are insurance companies and hospitals, so the most of the rate decrease in reimbursement for services has fallen heavier on physicians than it has on other parts of the industry, if you want to call that, and you have to remember that the corporatization is really something that has happened. Paul Starr's book in 1983, The Social Transformation of America Medicine really predicted this as it has come out. So I think all of these are factors. I think having said that the environment is a problem. I think most of us would do the same career. The pleasures of being able to take care of patients with the skills that you have as a surgeon are, I believe, unequal in any other field. All of us really enjoy what we are doing. We get tired of filling out forms, we get tired of having to argue with the insurance companies and some of which had some automatic rejection defaults billed into the billing, and the malpractice thing is still in absolute mess, but probably won't get changed as long as the trial lawyers have such a representation in the Senate. So those are problems that are there, but some of them are societal problems. The liability issue is actually higher for consumer goods than it is for medical services and it is this part of the mindset of our society today that's may be taking too far away from it, but I think Dr. Fisher is right. All those are contributing factors in the career issues, now having said all that there are things that keep coming into the literature especially about people choosing careers because of higher reimbursement. Many studies have not shown that to be a factor. I think that when I talk to students and people about it, that they have seen the work and the need to be accurate and everything that say a neurosurgeon or cardiothoracic surgeon does, this reimbursement is a little higher than some of the other fields and I ask him, okay you can make more money doing that, would you do it ? many of them do not see that as a life that they could be happy with.

Dr. RUTTENBERG:

So they are choosing a lifestyle over a compensation.

Dr. SHELDON:

Only in part, not just a lifestyle, it's just as specialty not all of us are equipped to do every specialty in terms of our own emotional makeup and stuff. I don't have value judgments on this and I think it's been a mistake to try to put value judgments on it. On the other hand, I think decreasing reimbursement and the other things that those of all occurred in an environment where overhead of running an office and paying malpractice is going up all the time and that makes it difficult. What is happening is at many places around the country you find, especially general surgeons, starting the work for hospitals who will do their billing and cover their malpractices and things like that. Now that has as Dr. Fisher mentioned in his article, the world health area is an area we are studying in the Health Policy Institute.

We have a number of counties in North Carolina where there are no general surgeons now or fewer than there were five years ago and there is a lot of reasons for it, but some of them are the ones mentioned in his article. A lot of it comes to the need to have an equipage in the local hospital that allows you to provide the care which you were trying to do. Not all of them have laparoscopic capabilities, so there is a whole bunch of issues that overlap in this and the problem though is that people keep seizing on one or two factors and it's usually like most things a little more complicated in that the income generating issue though where you are seeing that you can barely keep your office open because of all these things is an issue and many people resolve it by doing that or doing a local attendance.

Dr. RUTTENBERG:

You have done a great job outlining the problems. What do you see as solutions and what has been done so far to correct some of those rural physician shortages you just mentioned in North Carolina?

Dr. SHELDON:

Thank you. One of the things that is I think incompletely understood by many people is that there really are two routes to proving a physician or surgeon to a community, the country, or city, etc. One route is going through medical school, go to medical school and then you finish with an M.D., but you are not able to be licensed for at least one more year when you do graduate medical education, but states have developed medical schools in order to try to get the people live in that state to go to medical school and stay there and practice medicine. We believe that we are going to have too many doctors by 2000, lead to voluntary freeze on the number or medical schools in the country. There were 126 medical schools and there was no growth in them at all, in fact, there were one fewer one because all _____closed, 125 medical schools. With a realization only about four years ago we were going to be in this shortfall, medical schools who are closely associated in their professional, organizational life with the association of American Medical Colleges developed a workforce center and began to advocate increasing the number of graduates. That had a very profound and salutary effect. There is going to be probably somewhere between 13 to 19% more doctors turned out by about 2012 and with probably 13 new campuses. Some of these were being done like our Dean, Dr. William Roper here in North Carolina has developed the so called mini medical school satellite campus which we will have in Charlotte, North Carolina, will train 50 more students and many have followed that route which is a very good way to go. Others have been in states in the South West and the West which have been more recent in population growth to where they have many fewer medical schools in Western Mississippi than East of it. So a new pipeline of medical students is going to be coming out within 5 to 10 years.

Dr. RUTTENBERG:

But how do you keep them in the rural areas. Are you going to tie scholarship to service kind of like the military does where you get your education, but you have to do a payback.

Dr. SHELDON:

Well, actually that's available in many states including here and there is also the Health Service Corps. That is a very good way to do it. Some towns have done it on their own on a state basis there are programs like this in existence right now, but part of it is that in the perfect storm analogy that I am using, so we have corrected that part of the problem, but now we have not increased the number of finishing residency positions in general surgeries since 1980. Now there have been a few more, but not many. We can turn out all the medical students in the world, but if we do not have residency positions for them to go into, they obviously will not be able to provide the care. Meanwhile Medicare bypassed under Lyndon Johnson, they tied graduate medical education funding to Medicare Law. That was what was frozen by the Balance Budge Act in 1996, so we have the perfect storm of the voluntary freeze on number of medical school positions for many years and that in 1996 we froze it at the gradual medical education level, so we really put a throttle on it. Now I would not say as I have tried to indicate that the medical school thing has opened up. They recognized it and they have adapted. This has not

happened through the Accreditation Council for Graduate Medical Education yet, but a lot of it is due because Congress continues to freeze the number of physicians paid for under Medicare. So that needs to be attacked and we need to expand those and we need to allow hospitals to provide application for more positions and these need to be funded by, if not the Medicare Law, through some initiatives that have occurred in some states like Utah.

Dr. RUTTENBERG:

Pardon mu cynicism, but do we reach a point where it is just kind of like baseball expands and somebody gets these real weak teams, how far can we expand the number of medical school positions, how far can we increase the number of residencies before either the teaching quality starts to go down or the quality of the applicant starts to wane?

Dr. SHELDON:

There is only 10% to 15% more applicants probably of the same quality that we are able to get right now. We have been very blessed by the fact that women have come into medicine. I predicted we would not have kept up as well as we have. There were two women in my class in medical school in 1961. There is over 15 schools now have more women than men. Surgery has been a little slower getting women to come into it and to some others, but this year 44% of all first year residents in general surgery are women. So it's about there, it's getting there and that will help a lot and having said that the centennial generation or whatever you want to call it, the practice patterns of women in terms of number of hours worked and things like that or working for say a corporation or hospital provides fewer hours of service than men and this is not meant to be a gender comment, it's been a studied fact. Point being, that is a confounding factor in trying to figure out how many you need, it's unlikely that they will be able to get from them the number of hours that a lot of people put in, probably not the best thing in the world, but historically been done by doctors. So that needs to be factored into if we can figure out a way to do it. I think it's hard to know how far we can expand, but on the other hand the alternative is to keep recruiting people from countries that probably need the doctors worse than we do.

Dr. RUTTENBERG:

I would like to thank you so much for being my guest and we have been discussing reimbursements as well as other factors affecting the workforce in medicine today.

I am Dr. Bill Ruttenberg and you have been listening to the Clinician's Roundtable on ReachMD XM 157, the channel for medical professionals.

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