



Shari J. Welch, MD, FACEP

## When There Is No Doctor in the House

*Strategies for accommodating a physician shortage.*

Several advisory bodies, including the Graduate Medical Education National Advisory Committee and the Institute of Medicine, between 1980 and the mid-1990s erroneously projected there would be a surplus of physicians in the new millennium. However, for the past three decades, medical school admissions and graduations have been flat.

On average, fewer than 10,000 new physicians a year entered the workforce. Though medical school class size has steadily increased in the past five years—and this trend will continue—graduate medical education has *not* kept pace with physician demand. The limited supply of physicians that has resulted from this decline will be practicing at a time when shifts in demographics will overwhelm them.

### The Perfect Storm

By 2030, the population age 65 and older will double, according to the Administration on Aging. Those over age 65 consume healthcare resources at a higher rate than younger adults: Seniors will average six to seven healthcare encounters per year, while adults age 25 to 45 years average only 2.7 encounters annually.

Meanwhile, the output of new physicians will not keep pace with physician retirements, let alone with this increased demand for care. The Council on Physician and Nurse Supply anticipates a gap between retiring and graduating physicians of more than 200,000 by 2014. Coupled with this looming shortage is the fact that younger physicians place a premium on lifestyle and do not work the long hours of physicians from past generations. Some observers estimate that it will take 1.7 millennial generation physicians to replace each currently retiring physician.

Falling reimbursements have also contributed to the decrease in physician hours worked. A 2010 study published in the *Journal of the American Medical Association* showed that in the decade from the late 1990s to the late 2000s, physicians decreased their hours worked by 7.2 percent. According to the article, this “was temporally and geographically associated with lower physician fees.”

The physician shortage will be global, crossing geographic and subspecialty lines. The problem will be particularly felt in rural areas. While 25 percent of the U.S. population

lives in rural areas, less than 10 percent of physicians practice in these areas, according to the National Rural Health Association. A 2008 *Forbes* article called “Reasons Not to Become a Doctor,” by Tara Weiss, predicted that all of these factors will translate into average wait times of three to four months for rural patients to see a primary care physician and additional wait times to see a specialist.

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### Approaches to Addressing the Physician Shortage

Coping with the physician shortage requires healthcare leaders to develop new strategies. It helps to think about solutions to the problem with a two-pronged approach: first, recruitment and retention strategies, and second, expansion of physician capacity.

#### Recruitment Strategies

Recruitment of physicians in an era characterized by low reimbursement and physicians seeking work-life balance requires an understanding of what is important to them. To younger physicians, job sharing, hospitalist positions and amenities (such as the IT support that allows physicians to manage patient care from home) are attractive features when recruiting is competitive. In addition, newer physicians look for opportunities within a practice to

grow professionally and to gain and apply expertise in a certain area.

Some organizations are developing a robust recruitment program and strategies. According to Kenneth H. Cohn, MD, CEO of HealthcareCollaboration.com, these are beginning to include:

- CEO involvement and leadership accountability for recruitment
- Reimbursement to candidates for travel to interview
- Income guarantees for the first two years
- Assistance with medical school loans
- Courting of spouses via introduction to the community

#### *Retention Strategies*

Keeping senior physicians practicing longer can be part of the overall strategy, especially if it allows for part-time options and scheduling that takes into account the difficulties senior physicians may have with night work. New scheduling models, in particular for night hours, including those that allow for “prime sleep” (sleep between 9:00 p.m. and 3:00 a.m.) are being tested in specialties such as emergency medicine. Specifically, the use of shorter shifts that accommodate a few hours of prime sleep are being trialed around the country. Other institutions are exploring naps during night shift work. There is new interest in the topic of fatigue in healthcare since The Joint Commission released a sentinel event alert about the topic

in December 2011, and it is recognized that older workers have difficulty with night work.

Working with troubled and “problem” physicians is another approach that is gaining new attention in efforts to maintain a robust

physician workforce, and many healthcare organizations are putting resources behind these initiatives. The idea of counseling physicians or mentoring them to correct deficiencies has taken off at the local level and at the level of large national group practices.

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*Building Out Physician Capacity*

Given the pending shortage, many are considering strategies that build out or expand the physician's capacity, using his or her skills more strategically and off-loading tasks that do not require physician-level expertise. Some of these include the use of advanced practice providers (also called mid-level providers), hospitalist services, telemedicine and scribes.

A number of researchers, including Brent C. James, MD, executive director of the Institute for Health Care Delivery Research, are calling for the utilization of advanced practice providers—nurse practitioners and physician assistants—to help cover patient care services in the face of the impending physician shortage. Operating as a team and supervised by a physician under strict protocols, these providers can serve in primary care roles for many subsets of patients.

There is another important model that employs advanced practice providers and can help mitigate the on-call crisis being experienced around the country (the lack of physician providers to take call for the hospital and the demand for stipends to do so). In this model the advanced practice provider remains in the hospital to perform admission history and physical examinations on patients needing to be admitted during off hours, allowing the physician to come to the hospital before or after office hours or in the morning. This model is particularly helpful to small rural or critical access hospitals that might have only one

general surgeon on staff, for example. An alternative model involves the use of hospitalists to cover the facility during off hours.

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Telemedicine provides another way to build out physician capacity. Telemedicine has seen remarkable success in two unsung areas: rural medicine and psychiatry. In remote healthcare facilities, the Indian Health Service has built and delivered standardized telemedicine units that can transmit visual images of the patient. These units can also transmit auditory data from a remote stethoscope. All of this clinical information is transmitted to the off-site physician, who can diagnose and manage the patient from as far as several states away.

Similarly, the mental health provider shortage has ushered in entrepreneurial endeavors to fill the gaps in psychosocial services. Now that 31 states provide Medicaid funding for telemedicine, experimentation of its application in mental health has exploded. Using a hub-and-spoke model, with the psychiatrist in a central location, or hub, and telemedicine units spread

throughout the community, providers can conduct virtual psychiatric assessments for multiple locations almost simultaneously.

Most physicians report that documentation requirements for billing and coding, compliance and regulatory burdens often increase the time associated with charting and paperwork to the point that it exceeds the time spent at the bedside. Thus, another significant strategy for building out the capacity of physicians involves moving the clerical tasks that consume so much of the physician's time to others.

Scribes are trained to manage the physician's documentation tasks associated with patient care. The addition of scribes has been reported to increase physician productivity; improve documentation to support billing and coding and to reduce risk; and improve patient satisfaction. Many fast-paced clinical practices, such as emergency medicine, that have introduced the use of scribes report better physician retention, including keeping physicians near retirement age in practice.

The physician shortage is real. Your hospital and your healthcare organization should begin exploring strategies to manage it now, regardless of your location, size or demographic environment. ▲

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