Do We Need More Physicians or Efficient Health Care?

In the 1990s, workforce analysts were predicting a physician surplus. Today, the pendulum has swung in the other direction, with the AAMC calling for a 30 percent increase in medical student enrollment.

Baby-boomer physicians are nearing retirement at the same time the patient population is growing, aging, and demanding more specialized services, assert Edward Salsberg of the AAMC Center for Workforce Studies. In addition, many young physicians are choosing to work fewer hours -- especially true of the growing number of women in medicine.

Nonetheless, some still question the need for a dramatic increase. "There's a lot of shroud waving and fear mongering that's not based on evidence and will lead us on a costly expansion," said David C. Goodman, MD, of Dartmouth Medical ("A Growth Spurt for MedicalSchools," Chronicle of Higher Education, Jan. 12). "Rather than spending more resources on training more physicians, we should be focusing on building more efficient delivery systems."

Added author Daniel S. Greenberg, a self-professed "longtime skeptic of the need for more physicians," much of the need can be met by expanding the pool of advanced health care workers, like physician assistants or nurse practitioners. "We don't need to have people trained as brain surgeons taking splinters ou of people's feet," he told the Chronicle.

Even so, the nonphysician pool needs to grow significantly. A recent roundtable discussion hosted by the Association of Academic Health Centers found that workforce shortages are a key challenge across all health professions, not just medicine.

In the February issue of the GME e-Letter, we asked for feedback on this issue. Below are the responses we received from readers, with identifying information removed.

Do you have any answer to why so often the "experts" are dead wrong? I think it is because they want to be known and make an impact so they say things that are interesting and attention-getting with little veracity or data to back up their positions. Look at all the experts that advised consolidation of medica centers like UCSF and Stanford. This trend is now over because virtually every merger attempt was a disaster.

Remember the days when the experts said we need to generate more doctors so there would be more competition and lower costs? They gave medical schools additional funds to take more medical students. What happened? We generated many more doctors, but this just caused more money consumed by health care in our society rather than driving down costs.

I guess the other question is why do we (ie, leaders in academic medicine) ever listen to these so-called experts when they prove to be dead wrong so often Consider the ACGME's six general competencies. These were instituted at huge expense to all programs without one shred of evidence that they would turn out a better product. As far as I can tell, these six competencies simply came out of the head of David Leach, sort as if he were a religious prophet who hac the word of God come to him from on high.

I could make the same point about a lot of other regulatory bodies. So often they generate a regulation or mandatory requirement that is expensive withou data to show that they will be helpful. How about a small local pilot project first to show that these things make a positive difference? Why does organized medicine go out of its way to shoot itself in the foot and add extra costs that in the end serve to jack up the cost of medical care to the public?

I see no shortage if physicians were freed from the bureaucratic morass that "providers" have put us in, whose only purpose is to curtail the delivery of care for their own financial gain. Health care is not a commodity. If we treat it as such, it'll go the way our inner-city educational system has gone.

Clearly we need more health care providers to address patients' growing needs however, the key word is "providers." Efficient and effective treatment for basic health care issues can be provided by nonphysicians, such as advanced nurse practicioners or physician assistants. Importing physicians from other countries or training more physicians is not necessary when there are many US citizens who could fill our health care needs. I agree with Daniel S. Greenberg.

Kaiser, VA, and other large health systems use the "provider" model of care. Clearly, it works. We should train more nonphysicians as this would take less training time and dollars.

I cannot give you numbers and statistics to support my thoughts, but I can offer years of experience in private practice, public health settings, medical administration, and academic work. And based on that, I feel just the opposite of Daniel Greenberg--I am more concerned about those trained to take out splinters being pressed into brain surgery.

This is obviously an exaggeration, just as his comment is, but I have seen good, nonphysician clinicians get pushed into doing more than their comfort zone allows, and since they are helpful people by nature, they try to do what they're asked. It can end in poor care at best, and at worst, dangerous care.

The medical delivery system of today seems more impressed by how much money rather than how many lives it can save. I have worked with many excellen physician assistants and advanced practice nurses in my 30+ years of practice, but they and I always felt better that I was around to advise and assist when needed.

All professions that require time to train go through cycles in their available numbers--it has happened with teachers and nurses, and there is no reason to suppose that the physician supply would be immune to such cycles. It is clear that we need more physician availability in small, rural communities, and that is a matter of distribution rather than simply supply. But the only ways to accomplish a redistribution within our freedom-loving, capitalistic system are incentives to locate in such areas or market forces driven by additional numbers.

I agree with your points--governors need to be educated about the economic impact of physician shortages; GME needs more support if the educational system as a whole is to continue to turn out physicians in any numbers who are well trained, let alone in larger numbers; and medical education centers need more faculty members to accomplish their missions of education, research, and clinical service.

Replacing physicians with nurse practitioners and physician assistants is one approach to addressing the shortage of physicians, but begs the question of wha type of health care system we want.

With regard to Daniel Greenberg's profession of higher education, I am sure we could replace most college professors with lower-cost graduate students if we wanted to, but I doubt he would argue that that would improve the quality of a college education.

Replacing more highly educated professionals with paraprofessionals is not a formula for quality and rarely reduces actual costs. Experience shows that we just end up with another layer of expense and complexity.

In our 2001 paper on "Medical Care as a Commons"* we took issue with Uwe Reinhardt's assertions regarding the surplus of physicians. I had taken the position that the mismatch between advanced training versus service needs required primary attention. There is already widespread use of physician assistants and nurse practitioners, and that contribution to health care delivery will continue to grow. But I don't see evidence for a physician surplus now any more than 10 years ago, and in any event physician supply should at least track (more or less) the growth in the US population.

Our analysis focused on the different controls that patients, physicians, employers, insurers, and government exerted on the availability and payment for medical services. I don't think that supply can be separated from quality, and we advocated developing surrogate measures of quality such as time with patients and wait time. Since time with patients is a function of compensation schemes, this too must enter into national planning for physician training both at the undergraduate and specialization level. I see a danger in developing a national agenda that may look simplistically at supply and demand, without being able to address quality.

*Michael Gochfeld, Joanna Burger and Bernard Goldstein
Medical Care as a Commons, pp. 253-272 in "Protecting the Commons" (Island Press, Washington DC; 2001)

Always neglected in such discussions is the issue of the number of international medical graduates (IMGs) practicing in the US.

A principal reason that one may argue we have a sufficient number of physicians is because more than half of all physicians licensed in this country are educated in foreign countries. Whole regions of the US have a majority of physicians in practice who are not graduates of US medical schools (eg, the centra valley/Fresno area of California.

Does the US want to deprive so many of its citizens the opportunity to go to medical school in order to provide medical positions for graduates from foreign countries that often that place no limits, as the US does, on the number of medical school positions? Admission to a US medical school is a very rigorous process. Not only does this severely limit the number of US-educated physicians practicing in the US, but may also (as an unintended consequence) narrow th pool of applicants, which in turn may be adversely affecting the quality and character of the graduates.

Becoming a medical doctor remains a highly respected occupation in the US. Do we wish to continue to deny so many US citizens the opportunity to become medical doctors, thereby creating a large need filled by IMGs?

The time has come to address the most important implication of the ever-increasing numbers of IMGs providing care in this country. The problem is not the IMGs themselves. It is denying US citizens the opportunity to compete for these highly valued positions in our society.

Let the competition begin.

Although I agree that more PAs and NPs will meet many health care needs, Mr. Greenberg should not exaggerate his point, as it makes his argument less valid. "Neurosurgeons have no interest in removing splinters from anywhere except the central/peripheral nervous system."

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