

Physician Shortage Looms in United States

BY BRUCE JANCIN
Denver Bureau

COLORADO SPRINGS — America's physician shortage—still barely noticeable in many parts of the country—is here to stay and will grow much worse, panelists agreed at the annual meeting of the American Surgical Association.

"Because of our failure in the 1990s to recognize the needs of a new century, our health care system will have a continued shortage of physicians throughout the careers of today's medical students. We'll have to invent ways to deal with it, because none of us has ever experienced within our lifetimes in medicine a shortage of the sort we're building into the future," warned Dr. Richard A. Cooper, professor of medicine and a senior fellow at the University of Pennsylvania's Leonard Davis Institute of Health Economics, Philadelphia.

On the basis of economic and population projections, he estimated the nation will need 10,000 additional first-year residency slots and 60 new medical or osteopathic schools by 2020 to

control the crisis. By Dr. Cooper's estimate, there are now 5%-8% too few physicians nationally. "We're not feeling it everywhere because the shortage is early on, and it's not homogeneous nationally," he said, adding that the shortfall will grow to about 20% within the next 20 years. And physician assistants and nurse practitioners aren't being trained in sufficient numbers to be the solution.

Dr. Darell G. Kirch, president and chief executive officer of the American Association of Medical Colleges, Washington, praised Dr. Cooper for conducting the pioneering research that is awakening health policy planners to the looming physician shortage.

The AAMC is now recommending to Congress a 30% increase in U.S. medical school capacity. A 17% increase in capacity by 2012 is possible simply by maximizing existing capacity, according to the latest AAMC survey of the 125 medical school deans. An attractive additional strategy is to create regional or branch campuses of existing

medical schools, as many osteopathic schools are doing, according to Dr. Kirch, a psychiatrist.

"The Lake Erie College of Osteopathic Medicine in Erie, Pa., has established its regional campus in Jacksonville, Fla., and the Philadelphia College of Osteopathic Medicine has its regional



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DR. COOPER

campus in Atlanta, and the A.T. Stiles University Kirksville (Mo.) College of Osteopathic Medicine—the first osteopathic medical school—has a campus in Mesa, Ariz.," Dr. Kirch noted.

He also sees a need for more flexibility in the premedical curriculum. "We still have that emphasis on the core of calculus, physics, general and organic chemistry. How many of you in the OR have stepped back from a case and said, 'If I only knew

more calculus I could manage this case?' Maybe there can be more flexibility that would allow us to attract people who have got great intellects but aren't quite so oriented toward the physical sciences," he said.

The physician shortage is compounded by workforce exit issues.

Dr. Kirch cited a national survey done last year that showed one in three physicians over age 50 would retire now if they could afford to. But the survey also found that part-time work opportunities and less bureaucracy would keep physicians over age 50 in the workforce.

At present, less than two-thirds of residency slots are filled by graduates of U.S. medical schools. Most of the rest are filled by non-U.S.-citizen international medical graduates, many from developing countries where physicians are sorely needed. Adding more U.S. medical schools would increase the proportion of U.S. graduates in the postgraduate pipeline and keep more international graduates where they were trained, noted Dr. George F. Sheldon, professor

of surgery at the University of North Carolina at Chapel Hill.

Dr. L.D. Britt got a big hand from the audience when he told the panelists the time has come to "give up the ruse and declare what we already know—that the most wasted year in all medical education is the fourth year of medical school."

Eliminating it would make medical school more attractive and substantially cut the crushing student debt burden, argued Dr. Britt, professor and chairman of the department of surgery at Eastern Virginia Medical School, Norfolk.

Some medical students would benefit from having the fourth year count as their first year of residency training, Dr. Kirch said. Others enter medical school so highly qualified that much of the first 2 years are of little value. And there are way too many obstacles placed in the way of physicians interested in making a midcareer change in specialty, he added.

All papers presented at the 127th annual meeting of the ASA are subsequently submitted to the *Annals of Surgery* for consideration. ■

Coalition Releases 53 Disaster Planning Recommendations

BY MARY ELLEN SCHNEIDER
New York Bureau

Public health systems need more federal funding to respond to both day-to-day emergencies and mass-casualty events, according to disaster preparedness recommendations released by a coalition of 18 health organizations.

The coalition, which was led by the American Medical Association and the American Public Health Association, issued a report with 53 recommendations aimed at leaders in medicine and government. Other coalition members include the American Academy of Pediatrics, the American College of Emergency Physicians, and the American College of Surgeons. The project was funded under a cooperative agreement from the Centers for Disease Control and Prevention.

"The only thing we can probably predict with any certainty about terrorism attacks and other mass casualty events is this—we're not going to know the time, location, and magnitude in advance," Dr. Ronald M. Davis, AMA president, said at a press conference. "But we have no excuse if our responses aren't known in advance."

The report identifies nine critical areas needing immediate action, including:

- Increased federal funding should be allocated to expand emergency medical, trauma care, and disaster health preparedness systems across the country.

- Governmental entities and health systems must develop and evaluate processes to ensure a return to readiness for routine health care and future mass casualty events following a disaster.

- Funding for economic recovery after a disaster must emphasize the reestablishment of public health and health care systems.

- The Institute of Medicine should perform a comprehensive study of health system surge capacity.

- Emergency and disaster preparedness must be integrated with public health and health care systems nationwide to provide effective emergency and trauma care.

- Public health and health care officials must participate directly in disaster preparedness planning, mitigation, response, and recovery operations.

- Health disaster communications and health information exchange networks must be fully integrated and interoperable at every level of government and health systems.

- The government, health systems, and professional organizations should develop and distribute information on the management of adult and pediatric patients in day-to-day emergencies and catastrophic events.

- Public health and health care responders must be given adequate legal protections for providing care during a disaster. ■

The full report is available online at www.ama-assn.org/go/disasterpreparedness.

Sales of Most Timed-Release Guaifenesin Products to Stop

BY ELIZABETH MEHCATIE
Senior Writer

With one exception, timed-release drug products available in the United States that contain the expectorant guaifenesin have not been approved by the Food and Drug Administration and should be taken off the market, according to an agency announcement.

About 20 companies manufacture these products, most of which are available only by prescription. The products include Guaifenex (manufactured by Ethex Corp.), Crantex and Guaifen (Breckenridge Pharmaceutical Inc.), Amibid and Amitex (Actavis Group), Duraphen (Proethic Pharmaceuticals Inc.), Wellbid (Prasco), Ambi (Ambi Pharmaceuticals Inc.), and Maxifed (MCR American Pharmaceuticals Inc.). Many of the products include other active ingredients, the FDA announcement noted.

The FDA ordered manufacturers of these unapproved products to stop making them by Aug. 27 and to cease interstate shipment by Nov. 25, although some inventory will remain in pharmacies after that time.

The action does not affect immediate-release formulations of guaifenesin, only timed-release formulations, which are also described as extended release,

long acting, or sustained release.

The only timed-release products containing guaifenesin that have been formally approved by the FDA are those marketed over the counter as Mucinex or Humibid, by Adams Respiratory Therapeutics. Besides Mucinex and Humibid, which contain only guaifenesin, the company makes Mucinex-D, which also contains pseudoephedrine, and Mucinex-DM, which also contains dextromethorphan.

Timed-release products need to be approved because the FDA needs to ensure that "the product releases its active ingredients safely and effectively, sustaining the intended effect over the entire time in which the product is intended to work," according to the FDA statement.

Dose dumping is a major concern with these products, said Deborah M. Autor, an attorney and director of the office of compliance in the FDA's Center for Drug Evaluation and Research (CDER), during a telebriefing.

The FDA did not look into whether there were any reports of adverse events linked to the unapproved guaifenesin products; adverse event reports did not spur this action, Ms. Autor said. ■

The FDA's Web site on unapproved drugs is available at www.fda.gov/cder/drug/unapproved_drugs/default.htm