STUDY CONFIRMS SHORTAGE OF CRITICAL CARE DOCTORS

The country will need as many as 4,300 intensivists by 2020, a government report says. It predicts a 1,500-doctor shortfall.

Although demand for intensivists has increased after studies showed that care from the specialists can improve patient outcomes and shorten hospital stays, not enough young physicians are willing to take on the long, demanding hours of a critical care doctor, says pulmonologist Michael Alberts, MD, president of the American College of Chest Physicians.

A recent Health Resources and Services Administration report in collaboration with the ACCP backs that up. It estimates that by 2020, the nation will need at least 2,600 critical care physicians, or as many as 4,300. The current supply of 1,900 intensivists is expected to grow to 2,800 by 2020, which would appear to more than meet the minimum. But this lower estimate is based on a practice pattern that is quickly being eclipsed, according to HRSA.

Currently, one-third of patients in intensive care are treated by a critical care physician. But hospitals are pushing for a more optimal level of care, where two-thirds of intensive care patients are treated by an intensivist. To achieve this level of care, 4,300 intensivists would be needed by 2020, which, the study projects would mean a shortfall of 1,500 physicians.

The HRSA report cited lifestyle and reimbursement as the biggest barriers to boosting medical residents' interest in the subspecialty. "We ought to adequately compensate those who are at the front line with critically ill patients," Dr. Alberts said. "The current debt load of medical students means they need a payback quicker." Intensivists come up through one of three fields: internal medicine, surgery or anesthesia.

Dr. Alberts outlined several changes ACCP officials believe would increase the efficiency of the current critical care work force, raise the supply of critical care physicians and address patient demand for these services. They are to:

1. Support alternative delivery models, such as tiered systems of care.
2. Create more attractive practice models. Instead of a critical care physician shuttling between an office practice and the hospital intensive care unit, limit each physician's ICU coverage to a specific period.
3. Open more critical care fellowships, make compensation commensurate with the demands of the field and offer loan forgiveness for work in underserved areas.
4. Expand the J-1 visa waiver program to allow more international medical graduates to stay and practice in underserved areas.

By Myrle Croasdale [http://www.ama-assn.org/amednews/site/bio.htm#croasdale]

AMNewsstaff. June 19, 2006. Copyright 2006 American Medical Association. All rights reserved.