Response to "Analysis of the Workforce and Otolaryngology Specialty Planning" by Pillsbury

Jin Suk C. Kim, Richard A. Cooper and David W. Kennedy

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What is This?
Letters to the Editor

Analysis of the Workforce and Otolaryngology Specialty Planning
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I am writing regarding the article by Kim, Cooper, and Kennedy concerning workforce issues in otolaryngology. I have a significant interest in this area as I have published several articles over the past decade. I first heard of this accepted publication on the morning of the Workforce Committee meeting during the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) Annual Meeting. I was struck by the concept that many of the positions in this article were not representative of the committee’s deliberations. On a larger scale, however, several items merit discussion.

First, in Kim et al’s article there is an inference that one way to solve the impending workforce shortage would be to develop a 2-tiered residency with a 3-year primary certificate and 2 subsequent years of focused training in an advanced area. Since funding for residents encompasses only 5 years or first certification, it would be difficult to envision how we could support a 5-year residency with the present paradigm of funding from the Centers for Medicare and Medicaid Services. In addition, the idea of having a primary care otolaryngology residency would not serve the purposes of emergency call, etc, where an advanced level of understanding the pathology as well as having the capability to intervene in complicated cases might be diminished in an individual with only 3 years of training. If we train all of our residents for 5 years, we still do not have enough qualified people to perform all the procedures and evaluate all the people who are presently in need. Adding more insured individuals to the population, as planned, will do nothing but make this deficiency more acute.

Second, the present resident workforce is significantly more represented by women than it has been in the past. I would say that all young people are emphasizing lifestyle more than they did previously and that any difference in proposed productivity based on gender is inappropriate.

Finally, there is a concept that there are almost 8500 practicing otolaryngologists in the United States presently. According to the AAO-HNS Bulletin Leadership Message in October 2011, there are 7205 active fellows in the United States and Canada. Marketing experts who sell lists of otolaryngologists to various entities interested in mass mailing put the number closer to 7000 acting practitioners. It is clear that we are falling well short of the mark of what is needed in the United States for otolaryngologists. The sensible solution to this workforce shortage is to increase the opportunities to train physician extenders, including physicians assistants and nurse practitioners, instead of “dumbing down” our residencies to further exacerbate the problem of qualified surgeons.

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Response to “Analysis of the Workforce and Otolaryngology Specialty Planning” by Pillsbury
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We appreciate Dr Pillsbury’s comments. Although he raises concerns about the accuracy of the data sources, those utilized in the manuscript are the most recognized. However, the primary issues are not the absolute numbers but whether or not the current otolaryngology ratio/population is correct for the US scope of practice and whether this ratio is decreasing, especially in the face of an aging population. Evidence from multiple data sources indicates that this ratio has decreased and that this trend will continue.

We agree that the changing gender mix is not likely to be the major factor in developing future workforce full-time equivalent (FTE) projections and that differences identified historically elsewhere in medicine may narrow or disappear. Overall considerations include generational lifestyle preferences, an aging workforce, payment changes, and potential downstream effects of resident work hour limitations. Such effects are difficult to quantify. Accordingly, we developed different FTE discounting options but it should be recognized that there will be workforce shortages even in the absence of any discounting.

We agree that major effort should be made to attract mid-level providers to provide less intense services. Health care economics will demand this, but such specialty recruitment is insufficient to eliminate the workforce gap. Absent funding for additional postgraduate year 1 (PGY-1) slots, we need to examine creative solutions. Subspecialty training has been heaped upon a standard 5-year residency, with 50% of residents pursuing fellowships. It is therefore appropriate to reexamine residency design. Some such change occurred when otolaryngology took responsibility for PGY-1 and gained
additional specialty training. The service component could be further reduced. Recognizing that much of the funding for graduate medical education comes from public funds, does the public need an otolaryngologist who has performed major head and neck reconstruction or stapedectomy, or would it be more appropriate to have an otolaryngologist who can competently diagnose and manage the majority of disorders and provide appropriate referral when necessary? Can we learn from thoracic and plastic surgery, both of which reduced core training? Such questions certainly should be discussed. With regard to direct medical education funding, the portion that would be reduced by 50% after the first certification only constitutes a minority of overall residency funding, and that portion is dependent on Medicare patient mix.

Reducing the service component, and training a general otolaryngologist who can best serve the health care needs of the public, is not “dumbing down” residency training. It recognizes a changing time, the need for increased numbers of general otolaryngologists, and the trend toward increased subspecialty training. In addition to attracting physician extenders into the specialty to provide low-intensity services, we need to train otolaryngologists for high-intensity service growth opportunities, and this also requires a reevaluation of residency training.

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Re: Need for Bronchoscopy in Adenotonsilllectomy
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We are writing in reference to the article by Rastatter et al. We have concerns regarding their incidence of synchronous airway lesions (SALs). The corollary of their study is that one should perform a direct laryngoscopy and bronchoscopy (DL/B) on a 3-year-old undergoing adenotonsilllectomy, as there is a chance of finding SALs.

The authors do not distinguish between SALs and symptomatic SALs. Only 4 patients were found to have a SAL that warranted surgery; most were perhaps consequential. Detailing the preoperative examination of these patients would assist in determining if there were other factors suggesting the SAL.

Specific issues include the following:

1. The implication of tracheal cobblestoning in an asymptomatic child is unclear. This is a subjective, nonspecific finding.
2. It is unclear why adenoidectomy and adenotonsillectomy patients were grouped. The title states that the study group is adenotonsilllectomy patients.
3. The finding that more than two-thirds of their 3-year-old or younger patients undergoing adenotonsilllectomy have SALs leads to the speculation of selection bias. It should be clarified whether all adenotonsilllectomies performed during the study period were included in the study.
4. The significance of SALs in asymptomatic children is the larger question. Since this study does not have a control group, it is impossible to know how many children with adenotonsillar hypertrophy who do not undergo adenotonsilllectomy present with SALs.
5. It is not the standard approach to perform fiber-optic laryngoscopy and direct laryngoscopy and bronchoscopy on every patient younger than 3 years who undergoes an adenotonsilllectomy. In this era of tremendous health care cost containment and increasing scrutiny on physicians to show the value of our care that we deliver and how that relates to outcomes, each intervention must be justified.
6. Most SALs in table 3 can be perhaps explained with tighter scrutiny of the included cases. For example, one would think the patients with laryngomalacia would have potentially been identified in the office preoperatively, and finding such SAL at the time of the surgery seems to indicate the lack of clinical significance of the lesion in these patients. Hence, the default rate of significant SAL is in fact markedly lower.

We respectfully disagree with the premise of this study recommending flexible fiber-optic laryngoscopy and DL/B on all patients younger than 3 years undergoing adenotonsilllectomy. Their data do not support this assertion. The article would be strengthened if the rate of symptomatic SALs was reported.

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