Otolaryngology Workforce Planning: Why We Cannot Wait for Perfect Data

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In response to the commentary by Pryor et al1 published regarding the workforce study by Kim et al,2 I would like to address one source of concern—namely, the issue of the impact of changing workforce demographics and the necessity to change our specialty to meet this challenge. The issue raised regarding evidence for the accuracy of workforce projections in the Kim article has previously been addressed by Cooper.3

Pryor et al1 are correct that the issue of productivity in medicine is difficult to quantify and that physician work pattern differences have been identified between genders. Moreover, there is both a dramatically increasing female workforce within medicine and generational changes in life priorities. However, they are incorrect in assuming that we do not need to make changes. Our residency programs and practice patterns, and even malpractice insurance expenses, have been largely based on a previous pattern of 100% or greater effort, and I would argue that this is no longer appropriate. Failure to make suitable modifications risks making the specialty unattractive to medical students in general and alienating a potential majority of the future workforce, a workforce that is essential to the survival of the specialty.

Pryor et al1 appear to believe that the data in the article used by Kim et al2 might be used to “offer less generous compensation packages to women or even to avoid hiring female otolaryngologists.”4 This is clearly not the goal. This is not a gender issue. We need to make a spectrum of work options available to both men and women. If we don’t make the specialty flexible, we lose much of our potential future workforce. Given the coming shortage of otolaryngologists, this is not a viable option. Required changes may indeed include modifying our residency training programs so that appropriate time off for family reasons is not an almost catastrophic event, developing split position practice options, and lobbying for changes in malpractice less-than-full-time rates. Such changes will indeed require residency changes and incremental workforce over and above the incremental workforce growth that would otherwise be predicted, if the specialty scope is to remain unchanged. As vice dean, I was able to initiate a gender equity committee at Penn and encourage development of split positions within clinical departments. What we cannot do is to pretend that nothing is changing or to wait for perfect data. We need to move forward on the best available evidence, and such changes require additional workforce.

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References