American Journal of Preventive Medicine and Public Health, 2023
VOL 9, NO. 8, PAGES 01-03

SHORT COMMUNICATION

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The National Physician Shortfall: Charting a Course

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ABSTRACT

In recent years, increasing attention has been directed towards emergent healthcare workforce shortages, particularly in the primary care arena and certain high-demand specialties. Rural areas appear to have been especially hard hit. The SARS-CoV-2 pandemic shed a bright light on these challenges given the loss of thousands of healthcare workers to COVID-19, the profound increase in acute mental health challenges, and the growing threat of violence and harassment that drove many providers away from the profession. The provider shortages in question, by their very nature, could well lead to declines in the quality of care, longer wait times for appointments, difficulties in discharging patients to alternative care settings, and financial challenges for healthcare organizations. Ultimately, the healthcare workforce shortage could give rise to severe existential consequences for the very delivery of healthcare in the U.S. and for the wellbeing of its population. It is the objective of this piece to propose a research-driven roadmap for reimagining the roles of healthcare providers with an eye toward bridging gaps in services.

ARTICLE HISTORY

Received: 12-Aug-2023, Manuscript No. AJPMPH-23-110243; Editor assigned: 14-Aug-2023, PreQC No. AJPMPH-23-110243 (PQ); Reviewed: 29-Aug-2023, QC No. AJPMPH-23-110243; Revised: 05-Sep-2023, Manuscript No. AJPMPH-23-110243 (R); Published: 12-Sep-2023

KEYWORDS

Health care; Health equity; Patient outcomes; Trained NPs

About the Study

A broad array of proposals has been under consideration in the hope of pulling the nation's healthcare workforce back from the precipice. These proposals include the prospect of expanding the graduate medical education pipeline and thus increase the number of trained physicians, bolstering programs such as the National Health Services Corps with Health Professional Shortage Areas in mind, improving funding for loan repayment programs such as the Public Service Loan Forgiveness pathway, and decreasing licensing barriers for international medical graduates who wish to practice in the US. Collectively, these solutions have the potential of favorably altering the trajectory of projected workforce shortages. However, by themselves, these approaches will likely prove insufficient to address near-term consequences. Tackling the national provider shortage will also require the development of empirically driven stepwise approaches intent on reconfiguring the existing infrastructure.

Data from the National Resident Matching Program reveal that in 2021, over 42,000 applicants competed for approximately 35,000 first-year residency positions [1]. That same year, thousands of Physician Assistants (PAs), Nurse Practitioners (NPs), pharmacists, and other allied health professionals graduated from accredited programs. Ignoring the potential impact of these professionals would constitute a critical oversight. Indications are that these providers and caregivers could ameliorate the extant physician shortages through targeted reforms of care delivery. However, shifting provider SOPs must not be done willfully given the implications for organizational structure, payment strategies, and patient outcomes. Instead, a systematic and empirical approach is called for.

A striking illustration of such a paradigm was afforded by Weitz et al [2]. whose study explored the possibility that first-trimester aspiration abortions could be safely and effectively conducted by trained NPs, PAs, and Certified Nurse-Midwives (CNMs) rather than by physicians [2]. Notably, the study in question found no significant differences in the clinical outcomes of patients cared for by physicians *vs.* NPs, PAs, or CNMs [2]. These findings have since informed policy. In California, Senate bill SB 1375, signed into lawin 2022, makes it possible for "qualified nurse practitioners and certified nurse-midwives to provide first trimester abortions within

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the scope of their clinical and professional education and training." The principles undergirding the aforementioned study could well be emulated in crafting a national roadmap for healthcare workforce development that is designed to address unmet healthcare needs.

Similar evidence-driven, patient-centered approaches have been undertaken in other care settings. The treatment of addiction is one such example. Buprenorphine constitutes a life-saving substitute medication for patients experiencing Opioid Use Disorders (OUD). It was the enactment of the Comprehensive Addiction and Recovery Act of 2016 [Public law No: 114-198] that made it possible for advanced practice clinicians, including PAs and NPs, to prescribe Buprenorphine upon the completion of comprehensive training and the receipt of a waiver. Subsequent studies made note of the fact that the increased representation of NP/PA prescribers improved patient access particularly in non-metropolitan areas, without increasing the rates of adverse opioid-related health outcomes [3]. More recently, section 1262 of the Consolidated Appropriations Act, 2023 eliminated the requirement for health care providers to receive this waiver to dispense Buprenorphine for OUD.

Another paradigm worthy of consideration is that of the diabetes nurse educator. Diabetes nurse educators, a fixture of healthcare since the early 20th century, serve as care navigators capable of coordinating patient services while simultaneously fostering patients' capacity for chronic disease self-management. In the time since its inception, the role of the nurse educator was afforded with the requisite regulatory agency support, the national certification standards, and the codified scope-of-practice guidelines necessary to facilitate incorporation into the broader healthcare system. All told, the integration of diabetes nurse educators into care teams was shown to improve clinical outcomes in a cost-effective manner, thereby illustrating the value of tailored workforce remodeling [4].

The potential benefits of carefully shifting the SOP of non-MDs are numerous. However, proposed changes should be undertaken judicially so as to minimize further care fragmentation or the exacerbation of inequities in healthcare delivery. To identify critical care needs, it will be necessary to consolidate data on a national scale to better monitor workforce shortage areas by specialty, service, and geographic area so as to facilitate studies analogous to those previously described. Notable areas of exploration include identifying gaps in the provision of chronic care needs for conditions beyond substance use disorder or diabetes, as well as studying shortages in the context of services delivered by tele medical care. Within the veterans health administration system for example, the integration of pharmacists into telemedicine care teams proved effective in improving the consistency of care [5]. Following a spate of such implementation studies, it will be necessary for educational institutions, policymaking bodies, and organizations representing the various health professions to work in concert to explore the potential of task-sharing to better meet local and national public health needs. Such changes may entail federal-level guidance to shape relevant research priorities, concordance among health professional organizations regarding training requirements for providers, and state-level updates in SOP regulations alongside requisite reimbursement schema.

Conclusion

Addressing the provider scarcity crisis cannot be left for the next generation to solve. As the demand for healthcare services continues to rise in tandem with persistent shortfalls in the requisite healthcare workforce, we urge the undertaking of an empirically designed approach to reconstruct the national healthcare workforce in a fashion that maintains firm boundaries around certain SOP regulations while allowing for experimentation with others. The medical community is duty-bound to study, learn, and act in the patient's best interest through cautious, evidence-driven reforms intent on resolving the emergent shortage.

Declarations

None

Acknowledgements

None

Funding/Support

None

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