Support for General Surgery in Rural Areas: Draft for Discussion

The Council on Graduate Medical Education (COGME) wishes to draw attention to a growing national emergency of limited access to general surgeons who are an essential support to primary care physicians in rural and underserved locations. COGME presents three recommendations that will alleviate the nation's growing shortage of rural and critical access hospitals and the shortage of general surgeons, in rural, frontier, and underserved areas of the United States.

As described in COGME's 24th Report, twenty percent of the United States population lives in rural or frontier areas. However, only 9% of the United States health care workforce lives in these same areas. There are growing health care disparities in these rural, frontier, and underserved areas and results in increased morbidity and mortality. These disparities are directly linked to problems with timely access to high-quality health care as close to home as is possible. The recent pandemic underscored the impact of the rural hospital staffing shortages on the deficiencies in healthcare delivery experienced in rural communities.

Access to healthcare in rural regions is getting worse as local hospitals in these areas, including critical access hospitals (CAH), often unexpectedly close,. These closures are driven by two primary factors: healthcare workforce shortages and finances. In 2020, the U.S. experienced the highest number of rural closures in more than a decade with 19 hospitals in over a dozen states either converting to smaller hospitals with no inpatient units or closing completely. Primary care physicians in the specialties of family medicine, internal medicine, pediatrics, and obstetrics-gynecology are finding it increasingly untenable to continue working in these areas without the support of general surgeons and CAHs or clinics with short stay capacity. Training general surgery residents in rural areas and retaining general surgeons in these locations is key to averting CAH closures and the adverse effect on the community and primary care.

Residents who train in rural locations are more likely to practice in these settings, but there is a dearth of surgical training programs in rural areas. It is possible to train surgical residents in rural areas because of surgical specialists who intermittently attend or rotate at rural hospital centers. While the Centers for Medicare the Medicaid Services' (CMS) Fiscal year (FY) 2023 Medicare Hospital Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System Final Rule has increased flexibility to rural hospitals that participate in a rural track program, this change in policy is not specifically targeted towards increasing general surgical residencies in rural areas. The HRSA-administered Rural Residency Planning and Development (RRPD) program does include general surgery as an eligible specialty. However, only one RRPD grantee plans to develop a rural surgical residency and there are no dedicated funding programs to maintain such rural general surgical residency programs once started.

Primary care requires a cadre of healthcare professionals, including general surgical support, to meet the health needs and surgical services of rural communities. Bolstering the supply of general surgeons to be placed in high-need rural, frontier, and underserved communities is necessary to keep primary care doctors in these locations and to address growing health care disparities. The delivery of healthcare is no longer a single healthcare provider job. It is more

appropriate to consider that rural healthcare is best delivered by a team of healthcare professionals: the rural healthcare team (RHT), whose members are cross-trained to provide integrated healthcare delivery. The military has shown us that despite limited human capital, high quality health care can be delivered using an integrated team approach with members training and working together. This approach will allow the RHT to provide more healthcare per provider, be more comprehensive, and be more sustainable. An equally important aspect of this expansion of services is the financial preservation of the CAH because of the services and procedures that the team can perform. There is also increased continuity and decreased expenses from the avoidance of transferring patients from the CAHs to major centers for less complicated patients who can be kept closer to home.

While there are shortages of all the specialties that make up a RHT, the professional for which there is the least rural training options and the one that is most essential to be in-person is the general surgeon. Having the general surgeon as part of the team greatly expands the scope of work the team can perform, including preventive medicine (particularly cancer screening), acute and chronic care services, surgical services, and emergency services. Development of the RHT could be facilitated by including general surgery as an eligible specialty within the National Health Service Corps (NHSC) Scholarship and Loan Repayment Programs. However, general surgery is not currently included as an eligible specialty under statute (Section 331(a)(3)(D) of the Public Health Service (PHS) Act [42 U.S.C. § 254d(a)(3)(D)]), even though general surgeons are critical to sustaining primary care in rural NHSC-eligible areas. Furthermore, we need to fund the maintenance of rural residency programs specifically for general surgery at rural hospitals. If we do not act now, there will be a continued erosion of general surgeons in these communities and we will continue to see the citizens of these communities live sicker and die younger because of the lack of timely access to quality care.

Summary Recommendations

COGME proposes three urgent recommendations to help ensure a stable and consistent workforce in rural communities:

1) Fund the implementation of the RHT, emphasizing integrated training and including the general surgeon as a vital component of the team.
2) Restructure the NHSC Scholarship and Loan Repayment programs to support general surgeons who chose to practice in rural and underserved areas.
3) Fund the creation and maintenance of a training programs for general surgery residencies at community-based rural hospitals.