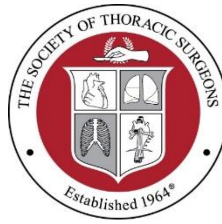
STS Headquarters
633 N Saint Clair St, Suite 2100
Chicago, IL 60611-3658
(312) 202-5800
sts@sts.org



Washington Office
20 F St NW, Suite 310 C
Washington, DC 20001-6702
(202) 787-1230
advocacy@sts.org

March 20, 2023

The Honorable Bernie Sanders
Chair, Senate Committee on Health,
Education, Labor and Pensions
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy, MD
Ranking Member, Senate Committee on Health,
Education, Labor and Pensions
United States Senate
Washington, DC 20510

Dear Chair Sanders and Ranking Member Cassidy,

On behalf of The Society of Thoracic Surgeons (STS), I write in response to your call for input on the drivers of healthcare workforce shortages across the country. Founded in 1964, The Society of Thoracic Surgeons is a not-for-profit organization representing more than 7,600 surgeons, researchers, and allied healthcare professionals worldwide who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lungs, and esophagus, as well as other surgical procedures within the chest.

Thoracic Surgery Has Largest Projected Workforce Shortage

We are on the precipice of a healthcare crisis and there is a critical need to train and develop our provider workforce. Thoracic Surgeons treat some of the most common and devastating conditions in the United States. Heart disease is the leading cause of death in the United States for men, women, and people of most racial and ethnic groups and accounts for 1 in every 5 deaths.[1] Lung cancer is by far the leading cause of cancer death. The American Cancer Society estimates that 127,070 will die of lung cancer in 2023 alone, or about 1 in 5 of all cancer deaths.[2] The Medicare population shoulders the majority of this disease burden—the average age of people diagnosed is 70.[3]

There are only around 5,000 thoracic surgeons in the United States, of which more than half are 55 years of age or older. The Medicare population – who are most frequently affected by heart disease and lung cancer – is expected to grow from 65 million to 77 million beneficiaries in 2032.[4]

The Health Resources and Services Administration (HRSA) recently projected there will be 900 less thoracic surgeons practicing in 2035, while total demand over the same time period would increase by 20 percent, resulting in only a 69 percent adequate supply of physicians within the specialty.[5] This is the largest projected shortfall of any physician specialty evaluated.

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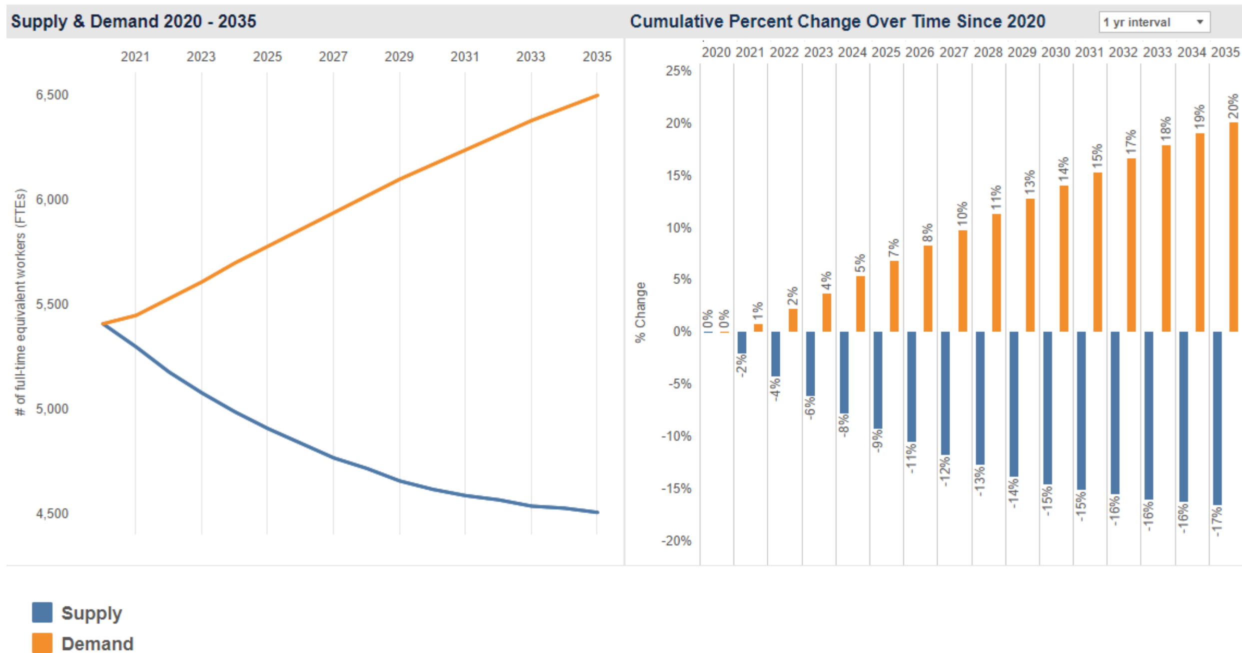
[1] https://www.cdc.gov/heartdisease/facts.htm#:~:text=Heart%20disease%20is%20the%20leading,1%20in%20every%204%20deaths
[2] https://www.cancer.org/cancer/lung-cancer/about/key-statistics.html
[3] Ibid
[4] https://www.cbo.gov/system/files?file=2022-05/51302-2022-05-medicare.pdf
[5] https://data.hrsa.gov/topics/health-workforce/workforce-projections

HRSA Projections for Thoracic Surgeon Workforce: 2020-2035



Despite these trends, few actions have been taken to address this long-term challenge. Meanwhile other factors such as the pandemic, additional administrative burdens such as complying with excessive prior authorization requirements, and financial pressures have all contributed to physician burnout being at record levels in recent years.[6] The growing uncertainties surrounding physician payments that regularly require congressional intervention, combined with the lack of an annual inflation update has contributed to physician burnout, even if solutions to this challenge are outside of the scope of this inquiry.

We recognize there is no universal solution to the healthcare workforce challenges across the country, but we believe many bipartisan bicameral solutions have been developed in recent years that warrant further consideration by the committee.

STS urges the committee to consider these recommendations:

- Increase the number of federally funded graduate medical education (GME) positions;
- Address rural workforce recruitment via student loan relief;
- Diversify the healthcare workforce; and
- Ban the practice of non-compete clauses in employer contracts.

GME Funding

[6] https://doi.org/10.1016/j.mayocp.2022.09.002

Our nation's public health and economy are linked to the effectiveness and availability of a capable and strong workforce. A key factor exacerbating this shortage is the artificial cap placed on Medicare-supported GME positions. In December 2020, Congress provided 1,000 new Medicare-supported GME positions – the first increase of its kind in nearly a quarter century. This momentum continued with the addition of 200 additional slots being provided in December 2022. While this progress is promising, there is still much more to do.

Advancing legislation such as the *Resident Physician Shortage Reduction Act* would build on this historic investment by gradually raising the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new slots. A share of these positions would be targeted to hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas, hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps.

We need bold action to address the shortfall of the 124,000 physicians that is expected by 2034.[7] Medicare-supported GME positions are essential to addressing the growing deficit of physicians which affects all Americans, especially the most vulnerable, like those living in rural and underserved areas.

Address Rural Workforce Recruitment via Student Loan Relief

A key challenge facing newly trained physicians, especially those from more underrepresented backgrounds, is student loan debt. The average cost of medical school in the United States reached $275,000 in 2020, with the average debt for recent graduates being around $200,000.[8] The average physician salaries during residency or fellowship training programs is around $61,000 during the first year and escalates annually to reach $83,000 by the eighth year.[9] The length of a training programs varies by specialty, from a minimum of three years to longer programs like thoracic surgery that typically take six to eight years. Often residents and fellows are forced to enter forbearance on their student loan payment due to the imbalance of high debt, training salary, and long length of training.

STS supports bipartisan legislation which has been proposed by Sens. Jacky Rosen and John Boozman, S. 704, *the Resident Education Deferred Interest (REDI) Act*, which would permit a pause on student loan interest accrual and principal loan repayment for the duration of medical residency and fellowships. The REDI Act does not provide any loan forgiveness or reduce a borrower's original loan balance.

This legislation would provide important relief for a specialty like thoracic surgery who have uniquely large workforce shortfall projections, combined with longer than average training requirements. Rural areas are even more dire for access to thoracic surgeons. There is already a tremendous gap in supply and demand that is projected to grow even wider over time. There is also a higher burden of lung cancer and heart disease in rural areas.[10] [11] In metro areas, thoracic surgery's workforce shortfalls are projected

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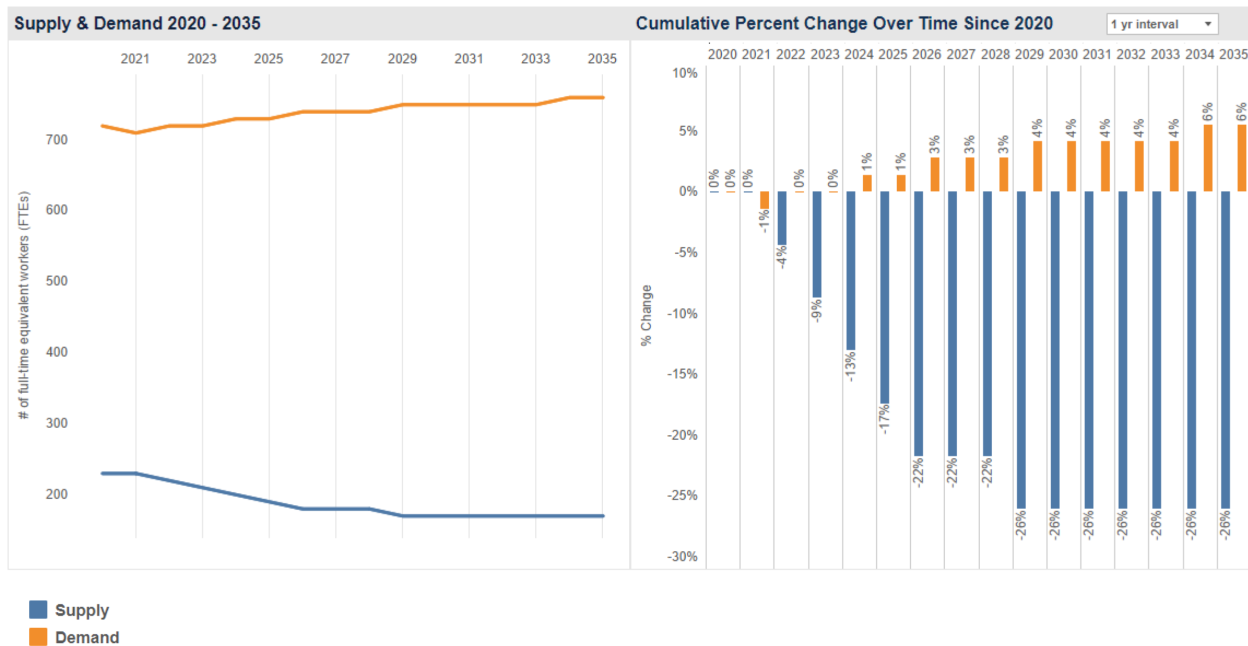
[7] https://www.aamc.org/media/54681/download
[8] https://store.aamc.org/downloadable/download/sample/sample_id/368/
[9] https://www.aamc.org/data-reports/students-residents/report/aamc-survey-resident/fellow-stipends-and-benefits
[10] https://www.annalsthoracicsurgery.org/action/showPdf?pii=S0003-4975%2819%2930879-3
[11] https://doi.org/10.1001/jamacardio.2022.5211

for future years due to reduced supply combined with increased demand. The REDI Act would allow all physicians to have a lower student debt burden, which could remove barriers to practicing in rural areas.

Another bipartisan bill that addresses the challenge of bolstering the rural physician workforce shortages is S. 705, *the Specialty Physicians Advancing Rural Care (SPARC) Act*, from Sens. Jacky Rosen and Rodger Wicker. This bill would create a repayment program for specialist physicians and non-physician specialty providers practicing in rural areas. As seen in the graph below, HRSA projects a large disparity between the supply and demand for thoracic surgeons practicing in rural areas. This bill could help to mitigate the workforce shortages specifically for rural providers.

HRSA Projections for Thoracic Surgeon Workforce in Rural Areas: 2020-2035



Diversify the Healthcare Workforce

STS is committed to the elimination of racial bias and disparities in healthcare. We recognize disparities exist in access to healthcare and health outcomes across race, socioeconomic status, and gender. We support policies that advances racial and socioeconomic equity in access to healthcare and health outcomes, while maintaining high quality care for patients.

Ischemic heart disease, lung cancer, and chronic obstructive pulmonary disease are leading causes of morbidity and mortality. Risk factors frequently overlap and include smoking, hypertension, obesity, and hypercholesteremia. These risk factors are highly linked to social determinants of health, which are frequently defined to fall along racial, gender, and socioeconomic demographic lines, laying the foundation for disparities in incidence, treatment, and patient outcomes.[12] STS has compiled extensive resources and discussion of factors effecting disparities in cardiothoracic diseases and access to care.

[12] Singh, Gopal K., and Ahmedin Jemal. "Socioeconomic and racial/ethnic disparities in cancer mortality, incidence, and survival in the United States, 1950–2014: over six decades of changing patterns and widening inequalities." Journal of environmental and public health 2017 (2017)

We believe more can be done by all actors in the healthcare system to diversify the physician workforce. STS has actively worked to educate, involve, and provide a voice to underrepresented groups within our membership. Our dedication and work are helping reshape the culture of the specialty. For example, STS membership is currently 86 percent male and 14 percent female, but the ratio is rapidly changing. The current Resident/Fellow membership category is composed of 69 percent male and 30 percent female providers.[13]

Despite these efforts, there remains a lack of racial, ethnic, and gender diversity in the physician workforce, which is reflected in cardiothoracic surgery. Black and Hispanic cardiothoracic surgeons are severely underrepresented in both the workforce and the resident/fellow pool. Current research suggests that increasing racial/ethnic and gender concordance between physicians and the patients they serve can positively affect the quality of care perceived and received by patients.[14] STS supports policies that incentivize recruitment, training, and retaining of a diverse physician workforce. Parental leave varies significantly by geographic location and by training program. Differences exist in both the amount of time permitted and pay offered. For actively planning parents-to-be, this creates a significant barrier of entry to longer training pathways or the consideration of time-consuming careers such as cardiothoracic surgery. STS encourages the Committee to consider solutions to addressing the need for improved options for parental leave, financial security during parental leave and educational, academic and promotional security.

Additionally, student loan relief, discussed above, will positively impact underrepresented communities.

Ban Non-Compete Clauses in Employer Contracts

STS supports the recent proposal from the Federal Trade Commission to ban non-compete clauses and urges the committee to support their reforms. As of January 2022, 74 percent of physicians are hospital or corporate employees. In a recent three-year study of employment performed by Avalere Health, 108,700 additional physicians transitioned to hospital or corporate employment. This trend of hospital or corporate employment is highlighted in the thoracic surgery subspecialty. Most thoracic surgeons perform procedures through a hospital-based practice (44.8 percent) or academic/university-based practice (33.6 percent).[15] **As the majority of thoracic surgeons are employed and not in private practice, they are impacted greatly by the requirements and terms of employment created by employers including non-compete clauses.**

Hospital and corporate employee contracts with non-compete clauses often prohibit a surgeon from working within a certain mileage/area. This means that when a surgeon leaves an employment agreement, they must relocate to find new work, often uprooting a family system in the process. Additionally, a 2007-2017 study found that 19 percent of hospital markets, which represented 11.2 million Americans, were served by one hospital system.[16] **The continuation of hospital consolidation**

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[13] https://www.sts.org/resources/diversity-and-inclusion-resources

[14] Wallis, Christopher JD, Angela Jerath, Natalie Coburn, Zachary Klaassen, Amy N. Luckenbaugh, Diana E. Magee, Amanda E. Hird et al. "Association of Surgeon-Patient Sex Concordance With Postoperative Outcomes." JAMA surgery (2021)

[15] Ikonomidis JS, Boden N, Atluri P. The Society of Thoracic Surgeons Thoracic Surgery Practice and Access Task Force-2019 Workforce Report. *Ann Thorac Surg*. 2020;110(3):1082-1090. doi:10.1016/j.athoracsur.2020.04.004

[16] Johnson, G., & Frakt, A. (2020). Hospital markets in the United States, 2007-2017. *Healthcare (Amsterdam, Netherlands)*, *8*(3), 100445. https://doi.org/10.1016/j.hjdsi.2020.100445

creates additional barriers to surgeons with non-compete clauses leaving an employment agreement. It unnecessarily reduces the career opportunities available for providers and affects the geographic distribution of surgeons by locking physicians into a specific employer rather than letting organic demand influence where and for whom cardiothoracic surgeons practice.

Additionally, there is a looming severe shortfall of thoracic surgeons. As previously mentioned, physician burnout in thoracic surgery is at an all-time high and unnecessarily being tied to an employer could further physician fatigue leading to continued workforce shortage. **Non-compete clauses create further hurdles for cardiothoracic surgeons' deciding on, or transitioning between, employment opportunities and could disincentivize thoracic surgeons from practicing in certain regions or systems.** The ban on non-compete clauses helps mitigate concerns around employment type and allows for thoracic surgeons to more easily decide on career opportunities that support their personal goals and community needs. By giving providers autonomy to make these decisions, it could help to address the workforce shortage by allowing cardiothoracic surgeons to be more competitive and create unique employment agreements that optimize their accessibility to patients.

Thank you for the opportunity to provide these comments. Please contact Derek Brandt, Vice President of Government Affairs, at dbrandt@sts.org, or 202-787-1223, or Molly Peltzman, Associate Director of Health Policy, at mpeltzman@sts.org or 202-787-1221, should you need additional information or clarification.

Sincerely,

Thomas E. MacGillivray, MD
President