Another View on Workforce Projections: A Bright Future, but the Details Can Be Cloudy

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I want to thank Dr. Yu et al. for a thought-provoking article on page 28 looking at possible causes for our workforce imbalance. While the hypothesis from Yu et al. that published workforce projections influence medical students' decision-making is plausible, there are other possible explanations. For example, emergency medicine (EM) physicians have the highest levels of burnout of all specialties, at 65%. They were especially taxed during COVID and continue to be challenged with high volumes, lack of bed capacity, and increasing workplace violence. Maybe medical students saw this distress in the EM faculty and residents and decided not to pursue EM as their specialty.

Regarding the Abt report on anesthesiology workforce requirements, this study was undertaken and published during a time where the advent of managed care was heralded as being able to reduce specialty care in general, including surgery. Of course, in hindsight, we see that never happened. At the time, this workforce study, amplified by a subsequent Wall Street Journal article, reinforced that general perception of an impending oversupply.

I disagree with some of the assumptions in the 2018 *Anesthesia & Analgesia* article referenced by Yu et al. that predicted an oversupply of pediatric anesthesiologists, but I also think that article is not the only reason residents are not choosing pediatric anesthesiology. There are currently over 2,000 jobs listed for anesthesiologists in GasWorks, most of which do not require specialty certification (asamonitor.pub/3tTn0c7). That is a lure for residents who may be paying back student debt to forego the opportunity cost of an extra fellowship year.

Predicting workforce supply and demand is difficult. Supply and demand are dynamic and shifts in one affect the other. Currently, there is strong demand for anesthesia services, and we are not able to increase supply sufficiently to keep up with attrition. However, in the next seven to 10 years, the specialty should get to a better balance between those coming into anesthesiology and those leaving with the increasing numbers of residents being trained and the large cohort of baby boomers having already retired. These changes will not completely solve the supply-demand imbalance, as more proceduralists are requesting anesthesiologists to be involved in procedures outside of the OR (NORA). An ASA task force has been charged with identifying approaches to improve the efficiency of NORA locations, developing risk-based staffing models for certain procedures, and identifying ways to actively manage sedation services.

In my prior role as chair of the ASA Physician Resources Committee (sunsetted) and my involvement in the Center for Anesthesia Workforce Studies (CAWS), I had been reluctant to predict the future of the anesthesia workforce. I will note that there are over 2,000 job openings for anesthesiologists, tremendous demand for anesthesia services, and a geographic maldistribution of anesthesia professionals. AMA data indicate large variations among the states (and within states), ranging from one anesthesiologist per almost 11,000 population to one anesthesiologist per 2,000 people (asamonitor.pub/3vwCVxh). My hope for the future is that ORs, NORA locations, and sedation sites would have the benefit of anesthesiologist-led care and that anesthesiologists operate in more efficient systems that improve the lives of its workforce (less travel, downtime for inefficiencies, etc.). The future is bright for our specialty and for all those training to become anesthesiologists.

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During this time of unprecedented demand, we need to work with hospital administrators and other physician leaders to decrease anesthesiologist attrition while we are building our workforce. ■

Disclosure: *Dr. Peterson is a former consultant for Medtronic.*