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Anatomy of a physician shortage

By Melanie Robbins '06M.A.

Why Nevada is hurting for doctors and nurses and all kinds of other medical professionals, and what, if anything, can cure the deficiencies.

Ann Simon can't find a doctor. The 26-year-old communications professional, who survived a childhood bout with cancer, moved to Reno from another state a year and a half ago. The cancer has been in remission for five years now, and her future looks bright.

But the chemotherapy and radiation treatments she underwent damaged her thyroid, an endocrine gland in the neck that produces hormones that regulate metabolism.

She needs daily medication and an endocrinologist to evaluate her and keep her on the right medicine. But she can't find one in her area and under her insurance plan who is accepting new patients.

"I've been seeing a nurse practitioner, instead," she says. "She evaluated my situation and has increased my medi-

cine dosage three times in the last three months. But I don't feel well."

Simon — a real person but not her real name — is experiencing the consequences of Nevada's continuing shortage of medical personnel. The state ranks last or close to last in the number medical professionals per capita in category after category: all physicians (46th), dentists (48th), home health/nursing aides or orderlies (49th), registered nurses (50th).

In some subspecialties, the shortage almost defies belief. For instance, this is the number of board-certified pediatric endocrinologists who

practice in Nevada:
Two.

If you've lived in Nevada for a long time and already have a doctor, the shortage may sound exaggerated. But for newcomers — Las Vegas and Clark County have 8,000 of those per month — it isn't. Immigrants typically have to call several doctor's offices



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before they can find even a family-practice physician accepting new patients under their particular medical insurance. OG-GYNs are especially overburdened, so much so that some Nevada women have given up trying to see such specialists for checkups and are settling for their regular family-practice physician instead.

IT'S NOT JUST NEVADA

The United States is facing a shortage of physicians. By 2020 the deficit will exceed 100,000, according to Edward Salsberg, director of the Center for Workforce Studies at the Association of American Medical Colleges.

One of the reasons is that, beginning in the late 1970s, medical schools heeded a warning from workforce analysts and public policymakers to reduce the number of medical school graduates. The consensus was that, without a cutback, the country would have a glut of physicians by the turn of the century. People thought managed care would reduce the need for physicians.

It didn't happen.

Since 1980, the number of graduates from traditional M.D.-granting medical schools has been essentially flat. Many active physicians are now reaching retirement age while the population is growing by 25 million people per decade, according to the U.S. Census Bureau. And it's an aging population, because of the baby boomers. The Census Bureau forecasts that the number of Americans 65 and older will double by 2030.

Elderly people consume the most medi-

cal services, so unless something changes soon, demand for medical services will outweigh supply.

In addition, some areas of medicine are facing particular shortages due to dwindling financial incentives to practice.

For example, doctors are shying away from traditional family practice because Medicare and insurance reimbursements are so low that even working 50, 60 hours a week, they can't earn enough to pay off their loans from medical school. Some have found they make a lot more money in less time doing what are often optional or cosmetic procedures. That's because no insurance reimbursement is involved; the patients pay cash.

Aside from ever-thinning profit margins in traditional doctoring, a cultural change has taken place, doctors say. The house call has long since become a relic of black-and-white television. But the new generation of doctors also isn't willing to work 80 hours a week like the physicians — principally male — who trained in the '40s and '50s, medical educators says. Many are looking for lifestyles that leave time for family — men as well as women, who are entering the physician workforce in numbers that will soon equal men.



Jean Dixon

People think of Nevada as being a doctor-unfriendly state following a 2002 malpractice insurance crisis, according to Dr. John Fildes, director of University Medical Center's Trauma Center and vicechair of the School of Medicine's Department of Surgery.

When you have fewer doctors, and the doctors are working shorter hours than previously, it only compounds the shortage.

A PERFECT STORM IN THE HIGH DESERT

Nevada is arguably worse off than any other state because of its rapid growth. It's been the fastest-growing state for the past 19 years, and the doctor supply simply hasn't kept up with the pace of immigration.

Dr. John McDonald, dean of the University of Nevada School of Medicine, says Nevada is facing the "perfect storm" of stress on the medical system: a growing and aging population, an undersized pipeline for producing health-care professionals, and difficulty recruiting physicians to move here from out-of-state.

The Nevada School of Medicine is the smallest public medical school in the United



States in terms of enrollment capacity, and Nevada has the fewest residency programs. A residency is the period of advanced training in a medical specialty that normally follows graduation from medical school. It's required to become licensed to practice medicine.

New physicians tend to stay in the state where they do their residencies. But graduates of the Nevada med school have no in-state opportunities to do residencies in neurosurgery, anesthesiology, pediatric psychiatry, pediatric endocrinology, cardiothoracic surgery, oncology and other important fields. Almost half of Nevada's med students fall into this nothing-in-state category, McDonald says. So they have to leave. And they usually don't come back.

To meet projected needs, the state must boost its ranks of physicians by more than 1,600 by the year 2015, according to John Packham, a researcher with the School of Medicine's Center for Education and Health Services Outreach. The center works to provide greater coverage of medical services for rural Nevada. With the School of Medicine graduating just 57 doctors a year, it won't come close to meeting projected demand. The state would have to rely on imports from other states and other countries.

Other forces have combined to reduce the number of Nevada doctors. A malpractice crisis in 2002 in southern Nevada caused the University Medical Center's Trauma Center to close for 10 days after doctors, overburdened by skyrocketing malpractice rates, left the practice. Insurance companies had raised premiums in response to high rates of litigation,

and one major insurer left the state altogether.

A special session of the legislature called by then-Gov. Kenny Guinn resolved the issue by putting a cap on malpractice claim payouts, but the episode set back efforts to recruit more doctors to the Silver State.

Dr. John Fildes, director of the Trauma Center and vice chair of the School of Medicine's Department of Surgery, says, "A lot of [doctors] remember the [trauma] center closing. People think of Nevada as being a doctor-unfriendly state."

Despite the malpractice-claims cap, malpractice insurance remains onerously high in Nevada compared with other states. For example, an OB-GYN in Clark County with five or more years of experience pays about \$100,000 per year. Similar physicians in Los Angeles pay about \$40,000 to \$60,000 per year, according to Don Roberts '89M.D., chair of the OB-GYN department of the medical school.

Why are malpractice insurance rates so much higher in Las Vegas than Los Angeles? No one knows for sure, but California has had its malpractice liability limits in place longer. Roberts speculates that the risk-taking, gambling culture that pervades Las Vegas may also prompt more people to try their luck in the court-room.



Photo courtesy of the University of Nevada School of Medicine

Marsha Matsunaga Kirgan, M.D., assistant professor of obstetrics, with University of Nevada Medical School obstetrics residents and students. Even if the school were to quadruple its current number of OB-GYN residency positions, it would take 5-10 years to have a meaningful impact in Las Vegas, says the medical school's OB-GYN chair.

One hopeful sign on the doctor-supply side is that the School of Medicine is gearing up to increase its graduates from 57 a year to about 100 by 2010. And Touro University, a private osteopathic school of medicine that opened in 2004 in Henderson, south of Las Vegas, has a class of about 100. (Osteopathic schools grant the D.O. degree, which adheres to a philosophy that disorders of the body can be treated by manipulative techniques in conjunction with conventional medicine. Osteopathic doctors constitute about 5 percent of the nation's physicians.)

Both institutions' graduates must complete residencies, but, as noted earlier, residencies are in short supply here. One reason for that involves the federal government. The feds long subsidized residency programs at hospitals in the interest of maintaining an adequate supply of medical professionals, but the government decided to stop funding additional positions in 1996 in a cost-containment move.

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“It’s as though the federal government froze the system and made no allowances for the rapid growth of a state like Nevada,” McDonald says. Now, if a hospital wants to increase its number of residents, it has to pay the cost entirely. This restricts additional residency training programs to hospitals that have never housed residency programs previously.

THE SOLUTION?

Training new doctors requires not only money for residency programs but for teachers and facilities — both classrooms for academic work and partner hospitals where students and residents can complete clinical training.

The solution proposed by the Nevada System of Higher Education is to create a Health Sciences Center, essentially a coordinating entity for the 200-plus health-sciences programs already in place at Nevada’s public colleges and universities.

The system is asking state lawmakers to appropriate:

- \$206 million for construction projects to house lecture halls as well as clinical and research facilities;
- \$29 million over two years to increase faculty;
- \$21.6 million as the first phase of doubling the state’s nursing program. (That program graduated 1,570 nurses in 2004-05. The goal is to get to 3,140 a year by 2013-14.)

The Health Sciences Center proposal calls for the initial \$206 million to come from the

state but the rest to be funded through a combination of tax money and private donations.

Backers of the plan say it would dramatically increase higher education in all areas of health and medicine and help the state’s medical system catch up with growth.

Opponents argue that the plan is vague and asks too much from taxpayers. Also, one critic in the medical community doesn’t like the idea of using taxpayer dollars to fund faculty physicians who would constitute competition. In actuality, tax money would go toward only the teaching portion of faculty doctors’ reimbursement. Doctors typically pay their own way via patients’ payments.

Jim Rogers, chancellor of the Nevada System of Higher Education and a strong proponent of the Health Sciences Center idea, says fears of competition are unfounded.

“The demand is much greater than the supply at this point. Even if we double the size of the medical school, it is not going to satisfy the need. My feeling is that we will still be 50th in the nation. Whatever we do should not affect the income of current doctors.”

The legislature is expected to take up the Health Sciences Center proposal this year.

In the meantime, the private sector responds.

Dwight Hansen, financial analyst for the Nevada Hospital Association, says hospitals have been adding beds in the last decade in response to population growth. The state still has one of the lowest ratios of hospital beds per capita, but because of the additional beds the situation at least hasn’t deteriorated. Further expansion is planned, including 10 new facilities and 15 expansions in southern Nevada, and four expansions in northern Nevada.

Renown Health (formerly Washoe Health System), based in Reno, has a 10-story wing slated to be completed by fall 2007. Plus the hospital is looking into building a women’s and children’s center.

Like many others in Nevada’s hospital industry, Renown also is bringing more doctors to the state. The company is offering income guaranties and relocation costs to physicians willing to move to Renown’s service area, according to recruitment officer Chris King.

THE PROGNOSIS

Whatever public or private groups wish could be done to ease the state’s shortage of medical professionals, the reality is that the problem isn’t going to be solved overnight. One reason: It takes the typical academically talented high school graduate 11 years to become a practicing physician.

Increasing a medical school’s capacity will take time, too. Roberts, the School of Medicine’s OB-GYN chair, says, “We need to double the number of OB-GYNs in Las Vegas from about 150 to 300.” But the residency program he oversees currently only accepts only three trainees per year.

He would like a dozen OB-GYN residency positions, but even at that level it would be five to 10 years before the program could make a meaningful impact on the market for obstetrics and gynecology in the Las Vegas area, he says.

Similar situations exist in other places in Nevada and with other medical specialties.

Until conditions change, it’s reasonable to expect the perfect storm to continue. **N**



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