WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

File Naming Example:

Record of Comm. Proceedings ... RCP

- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

COMMITTEE NOTICES ...

- *Committee Hearings ... CH* (Public Hearing Announcements)
- **

- *Committee Reports ... CR*
- **

- *Executive Sessions ... ES*
- **

- *Record of Comm. Proceedings ... RCP*
- **

INFORMATION COLLECTED BY COMMITTEE CLERK FOR AND AGAINST PROPOSAL

- *Appointments ... Appt*
- **

Name:

- *Clearinghouse Rules ... CRule*
- **

- *Hearing Records ... HR* (bills and resolutions)
- **05hr_ab0765_AC-In_pt03**

- *Miscellaneous ... Misc*
- **

Sunday

LEADER-TELEGRAM

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EMBATTLED SURGEON

Questionable operation

Concerns raised over doctor's numerous malpractice suits

By Traci Gerharz Klein, Eric Lindquist and Dan Holtz
Leader-Telegram staff

Since coming to Eau Claire 5 ½ years ago, Dr. Thomas V. Rankin has been the target of more than twice as many malpractice claims as any other neurosurgeon in Wisconsin, according to a Leader-Telegram investigation.

Narotzky

Immerman

Steans

Rankin, 57, who performs spine and brain surgery at Sacred Heart Hospital, has been sued 11 times in the past three years. An Eau Claire County jury found him negligent in one case, and three cases were settled out of court. The remaining seven cases are pending.

"I don't think you will find one other person in the whole world, who is a neurosurgeon, who has this pattern," said Menomonie attorney Michael Wagner, who has represented clients with claims against Rankin. "I think it's unusual for any physician, regardless of his specialty."

Rankin denied all charges but would not comment directly on the lawsuits. He conceded that 11 suits in three years are a lot but blamed another neurosurgeon's allegations — not his own actions — for prompting the string of claims in Eau Claire.

Rankin has had 12 claims against him registered with the state agency that handles malpractice cases since he began practicing at Sacred Heart in October 1993. No other Wisconsin neurosurgeon had more than five malpractice claims in the same period, according to the state Medical Mediation Panels, a division of the Supreme Court of Wisconsin.

During that time 61 percent of the state's 84 licensed neurosurgeons had no claims, and 93 percent had two or fewer claims, the Medical Mediation Panels reported. The agency tracks malpractice claims, which include lawsuits and requests for mediation.

Before coming to Eau Claire, Rankin was the target of several lawsuits in Florida, where he filed Chapter 7 bankruptcy to erase his debts in October 1992 after his malpractice insurer went out of business.

He filed a petition to reorganize his debts under Chapter 11 of the U.S. Bankruptcy Code in September 1996 in Eau Claire after accumulating $1.2 million of debt to the Internal Revenue Service and $90,000 of debt to the Wisconsin Department of Revenue for unpaid income taxes for 1994 and 1995, according to U.S. Bankruptcy Court documents. The filing showed Rankin also owed $436,000 to Sacred Heart Hospital for an unpaid loan. He estimated his gross monthly income for the next 11 years at $70,000.

While a record of malpractice lawsuits alone doesn't give consumers enough information to judge a doctor, it should raise a red flag any time a doctor has been sued that many more times than his peers, said Michael Donio, director of projects for the People's Medical Society, a national health care consumer advocacy organization based in Allentown, Pa.

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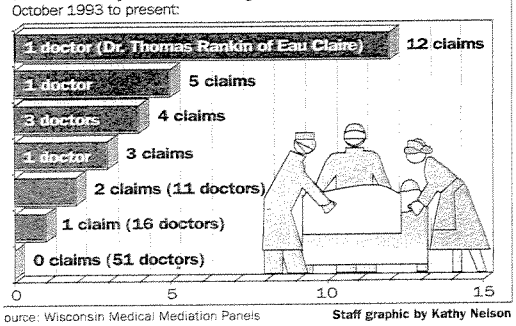
Staff file photo by Dan Reliand

Dr. Thomas V. Rankin, a neurosurgeon at Sacred Heart Hospital, has faced more malpractice lawsuits in Eau Claire County than any other place in his career, he said. Rankin, shown in this 1993 photo, was recruited to revive the hospital's neurosurgery program following the exodus of Midelfort Clinic neurosurgeons after the clinic and Luther Hospital merged with Mayo Clinic in 1992.

Malpractice Claims Against Wisconsin Neurosurgeons

Of the 84 licensed neurosurgeons in Wisconsin, here is a breakdown of how often they have been the target of malpractice claims from October 1993 to present:



Source: Wisconsin Medical Mediation Panels

Staff graphic by Kathy Nelson

Woman blames Rankin for mother's ailments

By Traci Gerharz Klein
Leader-Telegram staff

Judi Wolter's 78-year-old mother can't button her blouse, zip her coat, pull a sweatshirt over her head or lift a pan to cook a meal.

Wolter blames neurosurgeon Thomas V. Rankin for her mother's limited arm and hand use and nerve damage. Wolter, of Eau Claire, believes he performed unnecessary surgery on her mother.

Another neurosurgeon who treated Wolter's mother following her surgeries by Rankin plans to testify to that effect in June 2000, the date her mother's lawsuit against Rankin is scheduled to go to trial, Wolter said.

Wolter's mother is one of seven people with malpractice suits pending in Eau Claire County against Rankin. Four other former patients have received settlements or jury awards for their claims against Rankin since he began practicing at Sacred Heart in October 1993.

Rankin declined to comment on individual cases.

In January 1998 Wolter noticed her mother — whom she did not want to name for this story — started to become unsteady on her feet, get dizzy spells and fall.

Rankin said the cushioning between discs in Wolter's mother's neck was deteriorating, and he recommended surgery, Wolter said. "He said if it

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Doctor questions Rankin's work

RANKIN
from Page 1

"People definitely should take his history into consideration if they are referred to that neurosurgeon," Donio said, recommending patients do as much research as they can before submitting to a procedure by a doctor with a questionable record.

The 11 lawsuits filed against Rankin in Eau Claire County all deal with complications resulting from surgery. While the cases vary, many of the lawsuits contend Rankin performed unnecessary surgical procedures without considering less intrusive treatments.

"What I see evolving is a pattern of Dr. Rankin convincing people they need surgery they don't really need, and then I see complications that require a second surgery," Wagner said. "If you have a problem and it's him recommending surgery, I think you owe it to yourself and your family to get a second opinion."

In one lawsuit against Rankin, the plaintiff — Robert Determan of Red Wing, Minn. — contended Rankin punctured his lung because the screws used in the spinal surgery were too long.

In another suit, Brian Pierce of Chetek claimed Rankin aggravated his back problems and caused permanent nerve damage during spinal fusion surgery. Medical reports indicated Pierce, 36, suffered from chronic leg pain, numbness and weakness and was unable to stand for more than 30 minutes at a time.

Both Determan and Pierce required corrective surgeries by other doctors, the suits contend.

In Pierce's case an Eau Claire County jury in January found Rankin negligent and awarded Pierce $463,000, including $250,000 for past and future pain, suffering, disability and disfigurement. Determan's case against Rankin ended with a $65,000 out-of-court settlement.

Marlene Cartrette of Chippewa Falls sued Rankin because of complications — including a loss of strength and permanent nerve damage — resulting from an October 1996 surgery. The case was settled in March for an undisclosed sum, which Cartrette's attorney, Phil Steans of Menomonie, characterized as a "multiple six-figure amount."

In Florida, where Rankin practiced from 1987 to 1993, he had five malpractice claims against him. Three of the cases resulted in settlements, and two remain pending.

One of the suits claimed a 31-year-old Boca Raton woman woke up from a 1988 surgery with permanent brain damage. One claim against Rankin resulted in a $1 million payment by his malpractice insurer.

Another Florida suit on behalf of a paraplegic man in his 20s seeks millions of dollars for medical expenses, pain, suffering and the loss of earning capacity and enjoyment of life. The suit, scheduled for trial this fall, alleges Rankin failed to identify a spinal injury that, if treated immediately, might have prevented the man's paraplegia. The man's chances of collecting much appear bleak because Rankin shielded his assets when he filed for bankruptcy, said Lawrence Friedman, the Boca Raton attorney representing the plaintiff, who was injured in a motorcycle accident.

Upon learning Rankin has had 12 more malpractice claims since coming to Wisconsin, Friedman exclaimed, "Obviously, he should not be allowed to practice anymore. The medical review board has got to do something with repeaters like this. They're endangering the lives of patients.

"If he had that many cases down here, his license would have been pulled a long time ago."

Rankin also said he reached a settlement in one malpractice claim in Pennsylvania, where he worked for eight years before moving his practice to South Palm Beach County in Florida.

When Rankin applied for a license to practice medicine in Wisconsin, he submitted a large file filled with claims and lawsuits, according to the state Division of Health Professions and Services Licensing in Madison.

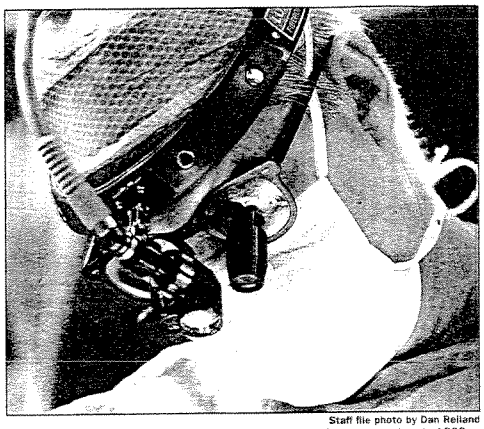
As a result Rankin was asked to take an oral exam, which required him to explain the lawsuits. He passed the oral and practical exams, and was granted his license.

In a recent interview, Rankin downplayed his litigation history by pointing out he has been sued 17 times in his 31-year neurosurgery career. He said he has performed more than 25,000 operations.

"It hasn't been that my skills have deteriorated," he said.

Rankin contended another Eau Claire doctor has tried to damage his reputation.

"Another physician in the community has indicated to this particular group of patients the care fell below the standards, and one might wonder what his motivation might be," Rankin said. "His actions speak for themselves, and we will leave it to the discretion of others to determine his motives."



Staff file photo by Dan Relland

Dr. Thomas V. Rankin wore special surgical glasses to perform a procedure in 1993.

Dr. Robert Narotzky, a neurosurgeon at Midelfort Clinic and Luther Hospital who left Eau Claire earlier this year to begin a practice in Wyoming, acknowledged he is the doctor to whom Rankin is referring.

"I got involved because I saw patients who were needlessly hurt," Narotzky said in a telephone interview from Wyoming. "A lot of physicians will turn their backs, but I felt I needed to stand up and get involved to the point of testifying about what I was seeing."

Narotzky said he performed "redo surgeries" on some of Rankin's patients and then ended up testifying against Rankin in some cases.

Narotzky saw several of Rankin's patients after Rankin operated on them and said he believes there were serious problems with Rankin's surgeries on these patients. Rankin performed unnecessary operations, and patients were harmed by the surgeries, Narotzky said.

"Complications were happening at a much greater rate and frequency than they needed to be," Narotzky said.

"They are coming out of surgery with new neurologic deficits," he said. "That should be a rare occurrence. You are not going to get a perfect outcome every time, but the risk of making somebody worse should be very low."

Wagner, the Menomonie lawyer, portrayed Narotzky as a brave person who has shown the willingness to do the right thing, even when it means taking the unusual step of questioning a fellow neurosurgeon.

Narotzky, who got involved in Cartrette's care after the operation by Rankin, testified on behalf of Cartrette in the case, and two other expert witnesses corroborated his opinion, Steans said.

"I've been doing medical malpractice for over 20 years, and I've never seen such a cluster of cases against one doctor in this region," Steans said.

Considering malpractice cases are difficult for plaintiffs to win, the record of cases against Rankin that led to payments suggests these are more than just idle complaints by unhappy patients, he said. "It would appear that there are problems with Dr. Rankin's practice," Steans said.

Still, state regulators haven't taken any disciplinary action against Rankin or placed any restrictions on his Wisconsin medical license.

A state Department of Regulation and Licensing screening panel reviews all cases in which a settlement is paid. The agency took no action after concluding its review of three Rankin cases — one of which prompted an investigation — earlier this year, said Michael Berndt, records custodian and attorney supervisor for the department's Division of Enforcement.

Berndt said he is prohibited from commenting on cases under review. While the agency doesn't automatically investigate physicians with unusually large numbers of malpractice claims, Berndt noted that screening panel members have the records of previous cases in front of them when new cases are reviewed.

Rankin's malpractice insurer has made payments in all four of the surgeon's closed cases in Wisconsin. By contrast, the Physicians Insurance Association of America reported that in 1997 only 28.7 percent of the closed claims against U.S. neurosurgeons resulted in payments to plaintiffs.

Of the 69 paid neurosurgery claims reported in 1997 to the PIAA — a trade association of more than 60 professional liability companies that insure about 60 percent of the nation's private practice physicians — the median payment was $225,000.

Rankin said he is a reviewer and examiner for a national neurosurgical peer review organization, which means one of his roles is to help investigate neurosurgeons who may have a large number of lawsuits in a limited amount of time.

"You have to look at each of the cases, but more than that you have to look at the total body of the person's work" to judge the surgeon's skills, he said.

People who hear about his 11 lawsuits in Wisconsin will not know about the rest of his career and will judge him incorrectly, Rankin said.

"I want to put it in context of my whole career," he said. "I understand very well technically and intellectually what (neurosurgeons) are supposed to be about, and this is why I am able to answer somewhat categorically why the charges brought against me are rather frivolous and self-serving."

For most of his career at Sacred Heart, Rankin has been the only neurosurgeon. For 15 months, from about January 1997 to March 1998, neurosurgeon Dr. Thomas Oravetz worked with Rankin.

As a result Rankin — whose practice consists of about 70 percent elective spine surgeries and about 30 percent brain operations — is available 24 hours a day, seven days a week to do surgery if necessary. He is searching for another neurosurgeon to join his practice.

"It's been a significant challenge," he said of being the hospital's sole neurosurgeon. "It's not a casual undertaking. It's a very demanding situation."

But neurosurgery gives his life great meaning, he said, because it's intellectually, spiritually, physically and technically challenging.

Rankin said he operates significantly more often than most U.S. neurosurgeons, who perform an average of 260 procedures a year, according to the American Association of Neurological Surgeons.

"If you are operating on 300 or 400 people a year, you are afforded the opportunity to do some significant good," Rankin said.

The numbers of surgeries he does varies from year to year, but he did the most operating during the Vietnam War when he was based at Brooke Army Medical Center at Fort Sam Houston in San Antonio, Texas, he said.

Huge numbers of soldiers were sent home to the United States for operations, said Rankin, a lieutenant colonel in the U.S. Army who began as a staff neurosurgeon and finished as chief neurosurgeon at the military hospital.

Lance Gambrell, now 15, the son of Leonard Gambrell and Lori Miller of Eau Claire, became one of Rankin's success stories in July 1997 when Rankin operated to remove a rare tumor growing in the 13-year-old's brain.

"This was life-threatening for Lance," Leonard Gambrell said. "Rankin said Lance could lose vision, he could lose speech. He went over this a half-dozen times with us.

"He had a very blunt demeanor and was professionally cold in that, but I'm not sure I'd be any different in that way."

Rankin told them he was as confident as he could be but that even with confidence, the operation might not go as hoped, Leonard Gambrell said.

Lance Gambrell is doing well today, but his type of tumor tends to return 30 percent of the time, his father said.

If it does return, "I wouldn't hesitate to have him do (the surgery) again," Leonard Gambrell said of Rankin.

Rankin also operated on Chrissy Schlageter, 12, of Eau Claire in December to remove an egg-size brain tumor.

Rankin told her parents, Mark and Jane, the operation was risky. "He was so honest with us I had to get up and leave the room," Mark Schlageter said. "I didn't want to hear that my daughter might die."

Chrissy Schlageter was like a newborn baby after the surgery and a subsequent coma. She needed to learn to walk and talk again, but she is making significant progress, her father said.

"If something would have happened to Chrissy, I would not have blamed Dr. Rankin," Mark Schlageter said. "He went into it to do his best."

Dr. Steven Immerman, a general surgeon in Eau Claire, operates with Rankin about twice a month and has recommended him to relatives who've needed surgery.

If Rankin needs to reach the spine from the front or side, Immerman is a surgeon called in to open the chest or abdomen. After Rankin does his surgery, Immerman returns to close the chest or abdomen.

What impresses Immerman is that Rankin accurately estimates how long it will take him to do his work, so Immerman knows when to return. "That implies that he knows what he's doing and how long it will take as opposed to him getting into problems," Immerman said.

"If I didn't think he was doing a good job and we weren't getting good results, I would be reticent to work with him," he said.

But lawyers who are handling cases against Rankin paint a far different picture.

In addition to the 11 lawsuits, Rankin has been involved in three mediation cases that have yet to result in litigation. All three cases were mediated last year, and none were settled through the mediation process.

Malpractice cases are heard by a state medical mediation panel consisting of an attorney, medical professional and member of the general public before a lawsuit can be filed. The purpose of mediation is to try and settle cases without litigation, said Steans, the Menomonie attorney who has represented plaintiffs in suits against Rankin.

Both parties can waive the mediation process, Steans said.

Wagner, the other Menomonie attorney, is investigating five more cases, and Steans is looking into three more cases that could result in new lawsuits against Rankin.

"It's nuts. (Potential clients) call almost every week," Wagner said. "I've never seen anything like it."

Wagner said he hears a common question from his clients and prospective clients in Rankin-related cases: "How come Sacred Heart lets him do surgery over there?"

In a statement, Sacred Heart's director of communications, David Duax, said Rankin leases space at the hospital but is not an employee.

The hospital monitors the performance of doctors who work there through a process called physician peer review. "Peer review involves ongoing review and analysis of a wide variety of patient care rendered in the hospital," Duax said. "This includes incidents of unusual or serious nature."

However, the review process is confidential under state law, and the hospital is not able to release information about specific doctors, he said.

In an interview, Duax said patients are the hospital's first priority. "As a Catholic hospital we want to provide the best possible care both from a medical and spiritual perspective," he said. "Secondly, quality improvement in all we do is a very high priority."

Rankin said his litigation history in his short time in Eau Claire and the negative perception of him by a few people leave an inaccurate impression. Many patients have been pleased with his surgical care, he said.

In addition, Rankin rejected the insinuation by some people that he is a "money grabber." It's not true, Rankin said, claiming that more than half of his work in Eau Claire is uncompensated and that he feels a moral obligation to care for people regardless of their ability to pay.

He wouldn't have been able to operate on large numbers of people in his career and "be a person with impaired judgment and moderate skills," he said. "That simply doesn't work."

Klein can be reached at 833-9206. Lindquist can be reached at 833-9209. Holtz can be reached at 833-9207. They also can be reached at (800) 236-7077.

> **"If you have a problem and it's (Dr. Rankin) recommending surgery, I think you owe it to yourself and your family to get a second opinion."**
>
> — Michael Wagner, Menomonie attorney who has represented clients with claims against Rankin

Rankin Cases

Following is a summary of the 11 malpractice lawsuits filed against neurosurgeon Thomas V. Rankin in Eau Claire County since 1996:

March 1996 — Robert Determan of Red Wing, Minn., sued Rankin and Sacred Heart Hospital, claiming Rankin's negligence while performing surgery led to the man suffering permanent lung damage.

The suit was settled in May 1998 for $65,000.

According to Determan's suit, he was admitted to Sacred Heart on Aug. 2, 1994, with injuries, including a fractured vertebrae, suffered in a motorcycle accident.

Three days later Rankin performed spinal fusion surgery on Determan, inserting screws to stabilize the fractured vertebrae.

The suit claimed Rankin inserted screws that were too long, puncturing Determan's lung, which required corrective surgery three weeks later at the University of Iowa Hospital.

September 1997 — Kristin Bonn of Durand sued Rankin, claiming he deviated from standard care by performing an anterior discectomy and fusion surgery.

Bonn claimed the June 13, 1994, surgery was unnecessary.

Bonn accused Rankin of failing to conduct appropriate diagnostic testing and ignoring findings on two MRI scans that were essentially normal.

Rankin used bone plugs from a bone bank during surgery instead of using bone from Bonn's body.

Rankin failed to take an appropriate health history of Bonn, which would have disclosed she was a heavy smoker and a poor candidate as a recipient from a bone bank, the suit claimed.

Rankin failed to inform Bonn of alternative treatments to surgery, including diagnostic testing, steroid injections and physical therapy.

The suit was settled last December for an undisclosed sum.

Bonn was seeking $500,000 in the lawsuit and offered to settle for $400,000 in September 1997.

October 1997 — Brian Pierce of Chetek sued Rankin for negligent care and for inadequately informing him of his medical condition before, during and after his Feb. 16, 1996, surgery.

Pierce's suit claimed his back problems were aggravated by Rankin's negligence, which included causing permanent nerve damage.

Rankin performed a spinal fusion on Pierce at Sacred Heart that failed. Pierce eventually had a second successful surgery at Luther Hospital, said Chuck Bye of River Falls, Pierce's attorney.

A jury in January found Rankin negligent in the care and treatment of Pierce and awarded him $463,000.

April 1998 — Kimberli J. Hansen of Blair sued Rankin for performing unnecessary surgery on March 22, 1995, without conducting normal and accepted diagnostic procedures.

Hansen injured her neck at work and was referred to Rankin.

The suit claims Rankin's negligence during surgery resulted in nerve impingement and permanent loss of nerve function, including numbness and weakness.

The surgery resulted in significant disfigurement at the site of the original bone graft harvest, the suit claims.

Hansen's suit against Rankin is scheduled for trial Aug. 10.

April 1998 — Marlene Cartrette of Chippewa Falls sued Rankin because of complications resulting from an Oct. 18, 1996, surgery.

Cartrette was referred to Rankin because of severe pain and numbness in her left arm and hand.

After she emerged from surgical anesthesia, Cartrette lost use of both arms and required prolonged hospitalization, the suit claimed.

Complications from the surgery included possible osteomyelitis and six weeks of antibiotic therapy.

The suit claimed Rankin failed to use the degree of care, skill, and judgment normally exercised by a neurosurgeon under like or similar circumstances.

The case was settled in March for an undisclosed sum.

November 1998 — Donald Allard Jr. of Holcombe sued Rankin for negligently performing an anterior cervical fusion on Allard on Aug. 26, 1994.

Allard's suit accuses Rankin of performing an unnecessary surgery and misdiagnosing Allard's neck problem.

Rankin failed to take an appropriate health history which would have disclosed that Allard was a heavy smoker. That made Allard a poor candidate as a recipient from a bone bank for the surgical procedure.

Rankin failed to give Allard sufficient information concerning his medical condition and the risks and benefits of treatment options, the suit claims.

Allard sought $400,000 in the lawsuit and made a settlement offer for that amount in January.

A trial date has not been set.

December 1998 — Mary Haun of Eau Claire sued Rankin for negligently recommending and performing two surgeries on her in January 1998.

Rankin failed to inform Haun of alternative treatment methods to surgery. Rankin failed to give Haun enough information about her medical condition before she opted for the surgeries, the suit claims.

Haun named Sacred Heart as a defendant for allowing Rankin to perform the surgeries.

The case is pending, and no trial date has been set.

January 1999 — Elke Nelson of Fall Creek sued Rankin because of negligence stemming from her Nov. 14, 1997, surgery.

The suit claims Rankin was negligent in his care of Nelson before, during and after surgery.

Nelson claims Rankin inadequately informed her about her treatment.

The case is pending, and no trial date has been set.

January 1999 — Damin P. Johnson of Eau Claire sued Rankin as a result of three surgeries performed by Rankin in 1996 and 1997.

Rankin was negligent by failing to disclose alternative procedures and the risks and disadvantages of the three surgeries, the suit claims.

That negligence didn't allow Johnson to make an informed choice about his care, the suit claims.

Sacred Heart is named in the lawsuit as a defendant for allowing Rankin to perform the surgeries.

Johnson has suffered severe temporary and permanent injuries as a result of the negligence, the suit claims.

The case is pending, and no trial date has been set.

April 1999 — Richard Lahner of Augusta sued Rankin for negligent care and treatment he received through April 16, 1996.

The suit provides no details about the type of care Lahner received from Rankin.

The case is pending, and no trial date has been set.

May 1999 — Anthony Dahlby of Colfax sued Rankin and Sacred Heart for negligence before, during and after Dahlby's surgery on July 1, 1996.

Dahlby claims Rankin failed to adequately inform him about the procedure and didn't obtain Dahlby's proper informed consent.

The case is pending, and no trial date has been set.

— Dan Holtz

Patient: Operation created new problem

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was not corrected and she fell, she would be paralyzed," Wolter said.

Wolter's mother woke up from the surgery with "excruciating pain down both her arms," Wolter said, adding her mother could not lift her right arm. Before surgery, she did not have arm pain, Wolter said.

When the pain didn't stop, Wolter was told by another doctor that Rankin had pinched a nerve during surgery and would fix the problem in a second surgery when he returned from vacation, Wolter said.

Following the second surgery, Wolter's mother's condition was no better, Wolter said.

Wolter had her mother transferred to another hospital, where a neurosurgeon told Wolter her mother was having small strokes but did not need the first surgery, Wolter said.

"The surgery had nothing to do with her symptoms, so she had a surgery she didn't need," Wolter said.

Wolter said Rankin created a new medical problem for her mother by performing a surgery that wasn't necessary in the first place.

Kristin Bonn of Durand echoes Wolter's sentiments when she talks about her own medical problems, which she said were worsened by Rankin's care.

Her case against Rankin was settled in December for an undisclosed sum.

"Maybe somewhere along the way he's helped somebody, but it's a shame that he's hurting the innocent people who don't need surgery," said the 34-year-old.

"As a victim, this is why I don't have good feelings about him," Bonn said. "In so many words he has ruined a lot of my life. He's taken away something that can't be given back."

In 1993, Bonn, then 29, was having severe arm pain and numbness in both arms. Rankin told her she had a pinched nerve in her neck. "He led me to believe I needed this surgery if I wanted to be out of pain," she said.

After surgery, Bonn's arm pain was no better, but she also had a new, severe pain — in her neck.

When she told Rankin on a follow-up visit about the arm and neck pain, he recommended a second surgery to replace a bone plug used from a bone bank in the first surgery, she said. One of the bone plugs had dissolved, she said.

At that time, he also diagnosed Bonn with carpal tunnel syndrome and told her he could do surgery on that at the same time, she said.

"That was a new diagnosis, and it sent some red flags up in my mind," Bonn said, adding that she had never been tested for carpal tunnel syndrome.

She sought a second opinion and was told she did not have carpal tunnel syndrome, she said. Bonn also was told the first surgery was unnecessary and she should have first been offered alternatives, such as pain medication, physical therapy or chiropractic care, Bonn said.

She was told a second surgery was now necessary because a bone plug had dissolved, said Bonn's husband, Mike.

Her own bone graft — which she said the body is more apt to accept — was used for the second surgery, which was performed by a different surgeon. She now has a plate and seven screws in her neck to stabilize it.

Five years after surgery, she continues to have pain and numbness in her arms, so bad that she loses sleep many nights. With further medical treatment, she hopes the arm pain will some day be controllable.

But the neck pain and lack of mobility are here to stay, she said.

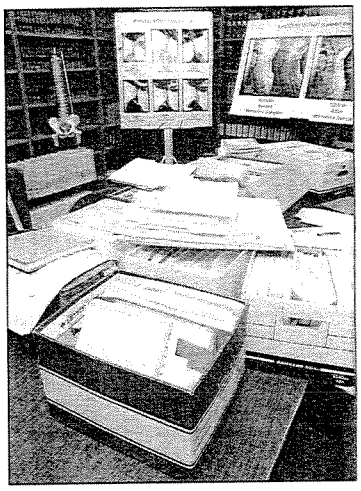
As a result, she can't back up her car without turning her entire body, and she no longer can deer hunt, play tennis and volleyball or shoot pool. The jolt of every sneeze and cough sends pain down her neck.

"When she has soup, she can't bend to eat it; she has to bring the bowl up to her mouth," said Mike Bonn, who now backs the car into the garage so his wife can drive it straight out.

She is not supposed to lift anything weighing more than 20 to 25 pounds, which is difficult for a mother of two young children, Michael, 1, and Kayla, who turns 3 in July. "I try not to pick them up, but when one of them falls I have to," she said.

Her dream of teaching preschool-through-kindergarten children may be just that because of all the movement required, said Kristin Bonn, who is nearly finished with her teaching degree from the University of Wisconsin-Stout. She will be certified to teach preschool-age children through third-graders.

"I think Dr. Rankin needs to be faithful to his patients and give them every alternative, and surgery should be the last alternative," she said. "We are trusting in (doctors). When somebody says surgery, they should mean that is the last option."



Staff photo by Mark Christian

With several malpractice lawsuits pending against Dr. Thomas Rankin and other potential ones under investigation, attorney Michael Wagner has assembled quite an array of files and supporting materials for the cases in his Menomonie office.

For Judi Wolter's mother, a third surgery by another doctor to correct problems from the first and second surgeries was ruled out. It was too risky because of her mother's osteoporosis and diabetes and because of the damage done to her nerves, Wolter said she was told.

So Wolter's father began taking care of his wife. He cleaned the house and cooked meals, and dressed his wife. He died of a heart attack in April while helping her get dressed, Wolter said.

When he died most of his retirement benefits stopped. His wife now lives in a local assisted living center but is $900 short each month to pay the cost.

Wolter and her sister took out loans to pay the extra money each month and have applied for further funds to pay for their mother's care.

"This lawsuit isn't for our own benefit," Wolter said. "I don't want a penny. I just want my mom taken care of."

Klein can be reached at 833-9206 or (800) 236-7077.

Suits also hit Luther neurosurgeons

By Leader-Telegram staff

In addition to Dr. Thomas Rankin, one of the three other neurosurgeons in Eau Claire has had malpractice lawsuits filed against him in Wisconsin.

Dr. Alfred Murrle, a neurosurgeon for Luther Hospital and Midelfort Clinic, has been named in two lawsuits since coming to Eau Claire in 1982.

No malpractice suits have been filed against Dr. Theresa Cheng or Dr. Shih Liu, both colleagues of Murrle's at Luther/Midelfort.

Cheng joined Luther/Midelfort in August 1995, and Liu arrived in the summer of 1998.

Dr. Robert Narotzky, who left Luther/Midelfort earlier this year to begin a practice in Wyoming, was named in five lawsuits during the nearly 20 years he worked as a neurosurgeon here.

In the first suit filed against Murrle in Chippewa County in 1993, Gladys I. Gotautis of Holcombe claimed the antibiotic therapy she received to treat an infection she developed after disk surgery caused her permanent injury.

A jury found Murrle was not negligent in his treatment. But the jury did find Murrle failed to adequately inform Gotautis of the risks and advantages of the antibiotic prescribed.

Elmer Nelson of Rice Lake sued Murrle in August 1997 stemming from a spinal fusion surgery in September 1994.

Nelson claimed Murrle failed to carry out the fusion at the correct and intended level. The suit claims Nelson sustained permanent injuries as a result of the surgery.

The suit was settled for an undisclosed amount in 1998.

The five suits against Narotzky all have been closed. A jury found in favor of Narotzky in the suit that went to trial.

In that lawsuit, Susan Gunderson of Eau Claire claimed Narotzky didn't get her informed consent before performing two brain biopsies in November 1985.

Gunderson's claim of lack of informed consent was denied, and the jury judgment was in Narotzky's favor.

Peter Selz of Eau Claire filed suit against Narotzky, who performed a lumbar puncture on Selz in September 1981 at Sacred Heart Hospital.

The suit claimed Narotzky failed to timely diagnose Selz's cryptococcus meningitis, failed to retest Selz and reported inaccurate information to another doctor.

A medical malpractice screening panel found Narotzky was negligent with respect to certain medical services rendered. The case was settled for an undisclosed amount.

June Gilbertson of Eau Claire claimed Narotzky used a halo pin that was tightened to the point where it pierced her skull and invaded her brain.

Gilbertson's suit claimed the incident caused her to have focal seizures, imbalance, confusion, muscle atrophy and poor speech. The case was dismissed.

Karen Retzloff of Menomonie sued Narotzky after seeing him in January 1986 for neck, arm and shoulder pain.

Retzloff claims the drug he prescribed caused her to have a reaction called Stevens-Johnson syndrome. The case was dismissed.

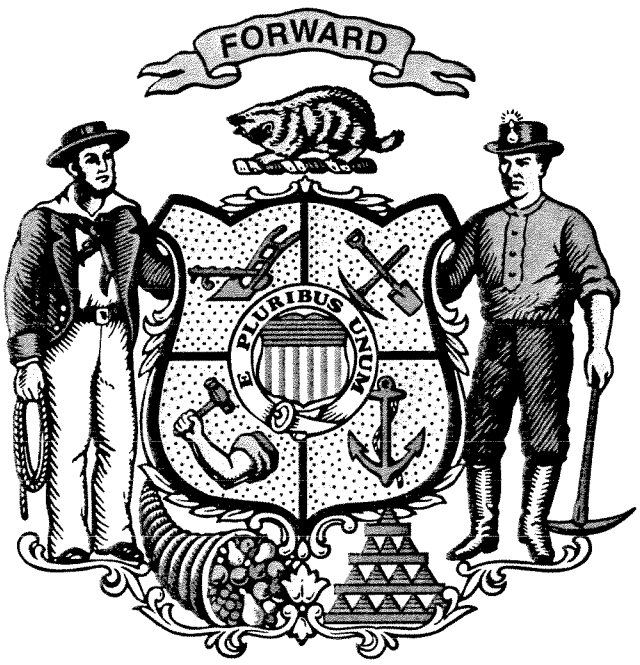
A former University of Wisconsin-Eau Claire student sued former Eau Claire neurosurgeon Peter Gianaris, Narotzky and Midelfort Clinic because of a 1993 spinal surgery that left him a quadriplegic.

The case filed by Derek Riebau was settled in June 1998 for $3.5 million. The settlement was paid only on Gianaris' behalf.

The lawsuit claimed Gianaris stuck a needle through Riebau's spinal cord during surgery. The action pushed the cord against a bone.

The suit claims the cord became herniated and compressed into the bone, causing quadriplegia.

The suit claimed Gianaris was negligent during the surgery at Sacred Heart Hospital. The suit said Narotzky supported Gianaris, who never had performed the procedure used during Riebau's surgery.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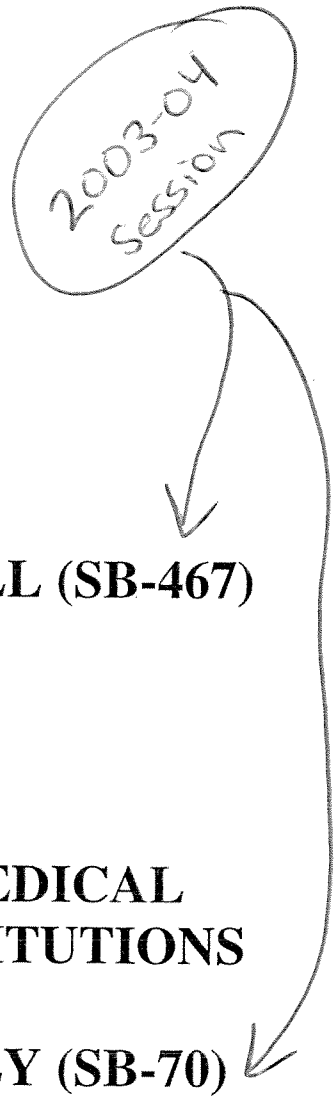


FACTS AND REASONS WHY

THE WISCONSIN FAMILY JUSTICE BILL (SB-467) MUST BE MADE INTO LAW --

AND

THE 180-DAY NOTICE RULE FOR MEDICAL MALPRACTICE FOR STATE RUN INSTITUTIONS AND STATE PHYSICIANS MUST BE REPEALED RETROACTIVELY (SB-70)

3 March 2004

FACTS AND REASONS WHY
THE WISCONSIN FAMILY JUSTICE BILL (SB-467)
MUST BE MADE INTO LAW --
A FACT SHEET FOR THE LEGISLATURE
March 3, 2004

Madison, WI. Did you know that if your single son or daughter is 18 or older and experiences medical malpractice and dies in Wisconsin that you, as a parent or sibling, will not be able to bring a claim for wrongful death against the wrong doers. Also, did you know if your single parent experiences medical malpractice and dies as a result in Wisconsin, that you as an adult child of that parent will not be able to bring a claim for wrongful death against the wrong doers. You will never find out what really happened, you will never get accountability, you and your family will never see justice. It will be tough to gain closure. Wisconsin law currently discriminates against two classes of people, single young and single elderly.

In this time of "family values", it is totally unbelievable that Wisconsin law does not recognize the life-long, and growing with age, bond between parent and child, regardless of the child's or parent's age and regardless of whether the parent is widowed or divorced. Up until now, the state law has been based on the bottom-line values of the health care providers, insurance companies, physicians' organizations and manufacturers and other big campaign contributors, not the family values held by the majority of Wisconsin citizens.

Wisconsin, of all states, you would think would be supportive of its citizen's rights. Not currently so. Six other states/districts in the US also have discriminating laws like this one, namely, Indiana, Florida, Maine, New Jersey, Maryland, and DC. Victims in these states are also fighting to change the law there to allow equality under the law. Forty-four states do not discriminate!

Wisconsin families who have suffered the loss of a family member due to apparent medical negligence have found the courthouse door slammed shut in their faces. In response, they have formed the Wisconsin Family Justice Network (WFJN).

A group of Wisconsin families, made up of both Republicans and Democrats from all walks of life, who suffered the loss of a family member due to apparent medical negligence, have been fighting to change the Wisconsin law back to what it was prior to 1995. We are a small group of families who now understand what the law means. The rest of the public still doesn't understand. We have few resources, but we must get the message out to the unsuspecting public, voters, media, and work with our legislators to get the law changed! The current WFJN members, their home towns, and their victimized family member are:

Jeanine & Lauren Knox Milwaukee (mother)	Jim & Donna Harvey Waterford (mother)	Sandy Gunwaldt New Berlin (mother)
Stephanie O'Connell Green Bay (father)	Sherry Ellis Oak Creek (mother)	Dan & Kim Leister Mukwonago (daughter)
Roger Fransway Chippewa Falls (sister)	Bernice Watts Brown Deer (daughter)	Lonny & Rhonda Brown Chippewa Falls (son)

Willie Davis
Milwaukee (mother)

John Zachar
Greendale (mother)

Judy Demeuse
Germantown (father)

Carolyn Walasek
Park Falls (mother)

Helen Szurovecz
Milwaukee (mother)

Pam Vertanen
Manitowoc (mother)

Susan Czapinski
Madison (mother)

Patty Schey
Wauwatosa (father)

Steve Janasik
Park Falls (mother)

Harriet Yancey
Milwaukee (father)

Sheryl Holdmann
Milwaukee (mother)

Jake Budrick
Saukville (mother)

Lee Davis
Menomonee Falls (brother)

Ray & Betty Lange
Beaver Dam (son)

Rosemary Halvorson
Readstown (mother)

Peter Torgerson
Colfax (mother)

Anita Harris
Milwaukee (son)

James & Dottie Webb
Whitewater (daughter)

Eric & Linda Rice
Middleton (daughter)

Dimitri Jordan
Milwaukee (mother)

James Bollig
Cottage Grove (father)

Sharon Kind
West Bend (mother)

Jonna Fedie
Hammond (mother)

Mary McBride
Madison (father)

Mack Kirksey
Brown Deer (mother)

Mary Siedschlag
Argyle (mother)

Kathleen Sese
Kewaskum (son)

Lee Brown
Milwaukee (mother)

Taron Monroe
Milwaukee

Michelle Martin
Green Bay (mother)

Phil Tipke
Cottage Grove (son)

Jeanne Hanson
Neenah (son)

Sister of Jackie Hemenway
Twin Lakes (father)

Mark Lavalle
Twin Lakes (mother)

Lisa Jacobsen
Darlington

The focus of the Wisconsin Family Justice Network (WFJN)—growing since being formed five years ago to over 45 families across the state—is now turning to the State Legislature, where Network members are working to build bi-partisan support for the passage of the Wisconsin Family Justice Bill (SB-467) and other legislation. This is not a political issue! Republicans and Democrats together should recognize that this problem needs fixing as soon as possible. We will not stop our efforts until we get the Wisconsin Family Justice Bill passed by the legislature and signed by the Governor -- our motto is *"We Will Not Stop Until Justice and Accountably is Available to all Wisconsinites"*. The bill is aimed at closing loopholes in current state malpractice law. In 2002, this bill passed the Senate, but failed to be put up in the Assembly.

A barrage of "mis-information" by opponents of the Wisconsin Family Justice Bill may again be upon us. Those trying to protect the unfair status quo will claim that Wisconsin's insurance rates will go up and that we will see doctors leaving the state or refusing to practice in nursing homes. But, malpractice costs are about one-half of one percent (0.55%) of all medical costs, so the claims of skyrocketing medical costs were plain ridiculous. 44 other states allow all families to have legal rights in malpractice cases, and they have not suffered any loss of doctors willing to practice.

Private malpractice insurance carriers are very healthy. The loss ratios for malpractice insurers from 1995 to 2000 are very low. During this period, the average loss ratio is 18. That is only 18¢ of every dollar the insurance company estimates it will pay on all malpractice claims. In addition, private physicians are compelled by state law to pay into the patient's medical compensation fund every year (roughly $30 to 55M per year). The fund now has grown to over $678,000,000. Because it is so big, the Governor wants to take some of this surplus to help the state's budget problems. These insurance rates should be going down! But they are not – why?

The Wisconsin Family Justice Network suggests that once you, as a representative of the people of this great State of Wisconsin, honestly consider the thoughts below that you will be compelled to support the Wisconsin Family Justice Bill. Try answering the questions below and we think you will understand exactly what we are fighting for.

- Do you believe that the bond between you and your parent and you and your child is life-long, and not eroded by age or marital status, but actually grows with age? Ponder that thought for a minute.
- How would you deal with the awful prospect of the loss of your own 18-year old son or daughter due to gross medical errors? How would you react with the fact that you can't get any legal representation because you are not allowed to have a wrongful death case under current Wisconsin law?
- Consider the prospect of the loss of your mother or father due to medical errors in a simple medical procedure and you can't get answers, accountability or justice.
- How would you deal with the fact that you can't get any attorney to take your case because of the current law constraints and limits?
- Do you feel comfortable with Wisconsin being one of ***just 6 states of 50*** that make arbitrary distinctions in legal rights, based on the age and marital status of the victim?
- Think about this, do you have less love? less compassion? less affection? or less connection to your family members when they become 18 or even when they become 60 years old?
- And finally, was it really the intent of the Wisconsin State Legislature to implement an biased and discriminating law that denies equal protection that says your loving son or daughter, over 17 years old and your single mother or father has **ABSOLUTELY NO VALUE.**

The Wisconsin Family Justice Network and the rest of the citizens of this state simply want a single standard of access to the courts and accountability for all citizens. It is a fundamental matter of equity and equality; the current law is biased, discriminating and totally unfair and must be changed!

FACTS AND WHY
THE 180-DAY NOTICE RULE FOR MEDICAL MALPRACTICE FOR STATE RUN INSTITUTIONS AND STATE PHYSICIANS MUST BE REPEALED RETROACTIVELY (SB-70)
March 3, 2004

Madison, WI. Did you know that if you are treated by physicians at UW Hospital & Clinics or UW Health/Physicians Plus and medical malpractice results in injury or death to your family member, you will not likely be able to bring a claim forward unless you have given notice to the state attorney general within 180 days after the event occurs? The current statute allows for discovery after this period; however, the most all the courts (case law) have made this tough to do. If you are late with your notice, not only will it be difficult or impossible to ever bring a case, but you may never find out what really happened, you and your family will never see justice, and the physicians won't talk and will never be held accountable for any of their errors/mistakes. Wisconsin law favors state physicians over private ones. Did you also know that state-employed physicians do not have to pay medical malpractice insurance? The state self-insures them. Private physicians and organizations remain outraged by this and the 180-day notice rule.

Again, Wisconsin families who have suffered the loss of a family member due to apparent medical negligence have found the courthouse door slammed shut in their faces.

A group of Wisconsin families, made up of both Republicans and Democrats, who suffered the loss of a family member due to apparent medical negligence have been fighting hard to fix Wisconsin law. We are a small group of families and we have few resources, but we must get the message out to the unsuspecting public, voters, media, and work with legislators to get the law changed!

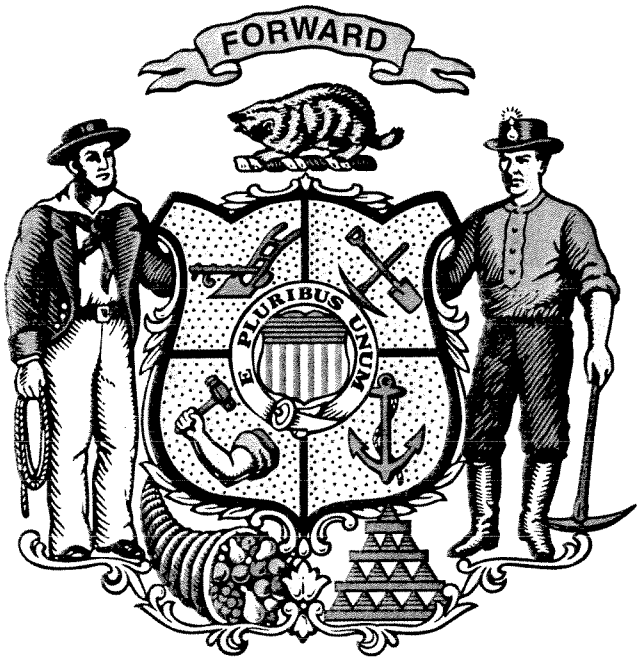
The focus of the Wisconsin Family Justice Network (WFJN)—growing since being formed five years ago to over 45 families across the state—is now turning to the State Legislature, where Network members are working to build bi-partisan support for the passage of the Wisconsin Family Justice Bill and now, the repeal of the 180-day notice rule for medical malpractice by state healthcare employees. These are not political issues! Republicans and Democrats together should recognize that these problems need fixing as soon as possible. We will work to get the retroactive repeal of the 180-day notice bill passed by the legislature and signed by the Governor. Senator Fred Risser, a Democrat, has agreed with Dr. Eric Rice, a Republican constituent of Senator Riser, to again to whole heartedly sponsor this year's bill. Last year, it passed the Senate by voice vote, but never was introduced to the Assembly.

The Wisconsin Family Justice Network suggests that once you, as a representative of the people of this great State of Wisconsin, honestly consider the thoughts below that you will be compelled to support the repeal of the 180-day notice for medical malpractice claims for state healthcare employees.

- For example, how would you deal with the awful prospect of the loss of a loved one due to gross medical errors at UW Hospital? After much grief, you finally get around to talking with an attorney and then the attorney tells you how sorry he or she is, but you missed the 180-day notice deadline and your potential legal claim is now likely void! You, like almost everyone, thought you had 3 years to respond. This happens all the time to grieving families!

- How would you react to the fact that you can't get any legal representation because you are not likely to have a case under this current Wisconsin law if you are late with your notice of claim?
- Was it really the intent of the Wisconsin State Legislature to implement a biased law that denies Wisconsin citizens their rights for justice and accountability?
- How are you ever to know about the 180-day notice rule? Have you ever heard of it before? The public does not know. Check out your constituents – ask them if they know. We would bet that none do, except us and our close friends.
- If you loose a loved one at the UW Hospital, do they tell you have only 180 days to file a claim for malpractice with the Attorney General's Office? No. Of all the forms one has to sign in the hospital, is there a form that you sign in the hospital that says you have 180 days to file a notice of claim if the hospital were to perform malpractice? No!
- Private health care providers (HMO's etc.) and UW co-mingle their employees at the HMO and UW Hospital facilities. How do you really know which physician is a UW employee and which one is with the HMO private provider? Which ones do you give notice to, if you knew of the rule?
- If medical malpractice occurs, it seems to take forever to get a copy of the medical records. This cuts into your time to assess and decide if you have a claim or not with the 180-day rule. We don't need to be filing notices of claim if we are not sure! Time is needed to assess the medical records and have other expert physicians review what happened.
- For sure, the 180-day rule is likely never to be known by a grieving family.
- One should believe that there should be fairness and equal protection under the law for all Wisconsinites, regardless of what hospital they go to, but is not currently the case.
- It's obvious that this law is aligned to protect the insurance companies and the UW physicians; not the patients and their families. The law is biased to benefit state employees and state-run medical facilities.
- Private physicians are outraged by this discrimination and that the State self insures them at no cost.

The Wisconsin Family Justice Network and the rest of the citizens of this state simply want a single standard of access to the courts and accountability for all citizens. It is a fundamental matter of equity and equality; the current law is biased, discriminating and totally unfair and must be changed! The retroactive repeal of the 180-day notice for state medical employees needs to be made ASAP so more people are not totally defeated by this unfair and biased favoritism.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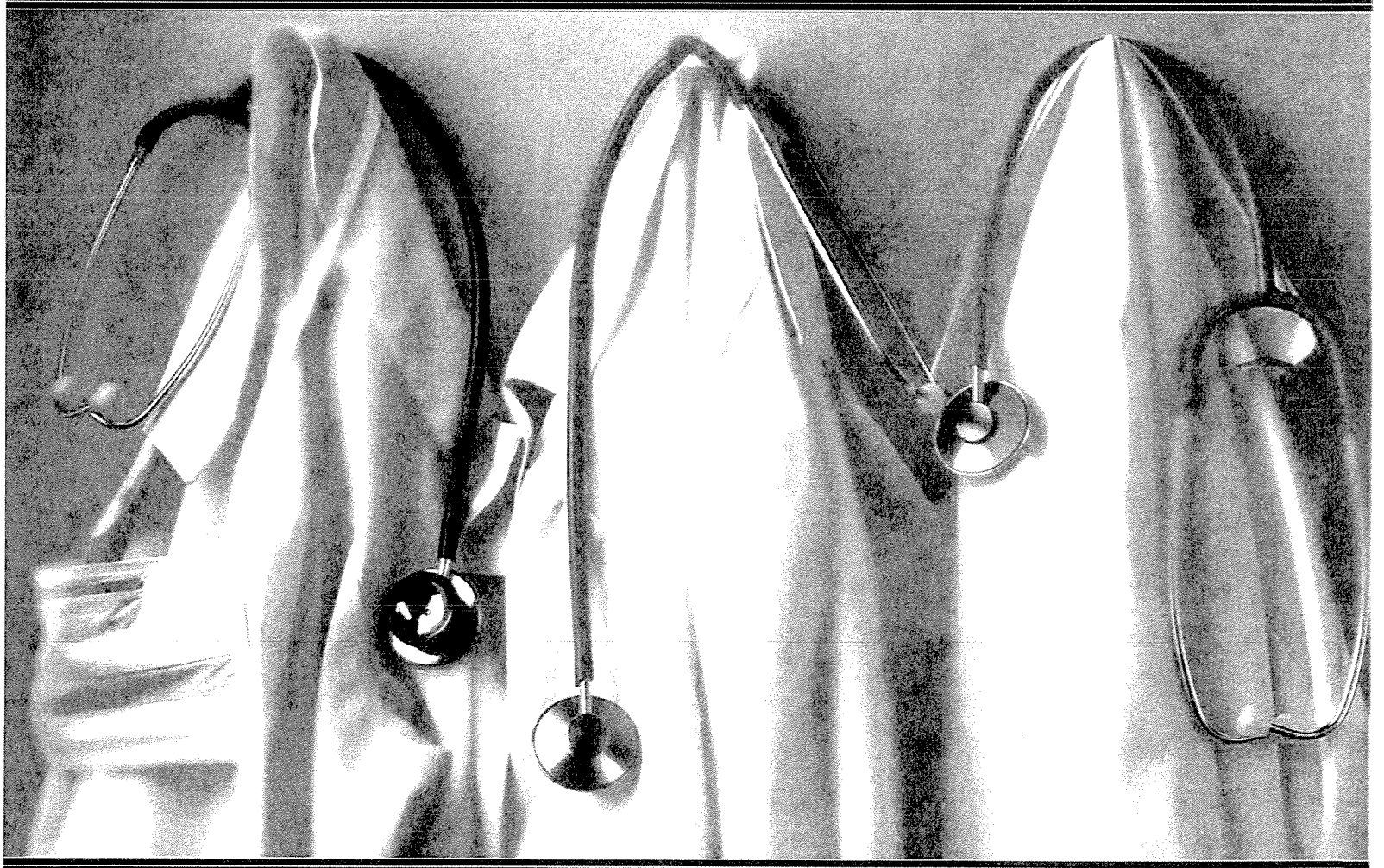
Who Will Care For Our Patients?

Wisconsin Takes Action to Fight a Growing Physician Shortage



A report by the Wisconsin Hospital Association and the Wisconsin Medical Society.

Who Will Care For Our Patients?

Wisconsin Takes Action to Fight a Growing Physician Shortage

March 2004

A report by the Wisconsin Hospital Association and the Wisconsin Medical Society

Executive Summary

In early 2003, the Wisconsin Hospital Association, together with the Wisconsin Medical Society, established a Task Force on Wisconsin's Future Physician Workforce. The charge to the Task Force was:

- Undertake a needs assessment of current and future physician supply and distribution issues.
- Identify factors that are impediments to meeting those needs.
- Find specific strategies that will help assure adequate future access to physicians for Wisconsin patients and communities.

The work plan included the following tasks:

- Understand the current supply of physicians in Wisconsin.
- Identify and understand issues relating to estimating physician demand.
- Estimate the current and future demand/need.
- Identify strategies for meeting the specific needs.

Task Force membership included representation from physician practice groups, the Wisconsin Medical Society, the Wisconsin Academy of Family Physicians, hospitals and health systems, the medical schools in Wisconsin and others. Four meetings were held. Information and data were shared that represented a number of perspectives on the issue. This final report provides a comprehensive set of recommended solutions to the physician shortage problem.

Conclusions Regarding Physician Supply

After reviewing existing data and analysis, the Task Force concluded that an unmet current need exists for physician services and that the problem will likely grow worse in the future unless aggressively managed.

The current supply is not sufficient when measured several different ways:

- There is a shortage of primary care physicians in rural Wisconsin and inner city Milwaukee.
- In general, non-primary specialty physicians are in demand and are hard to recruit on a statewide basis.
- General surgeons and radiologists are critically needed in rural areas.

These unmet needs are projected to grow even more in the future. By 2015, we anticipate demand for physicians to grow:

- By an additional 13.5% for primary care physicians.
- At rates exceeding 20% for all other physicians.

At the same time, physician supply is projected to lag even further, due to projected negligible growth in Wisconsin's physician workforce over the next 10 years. This compares to a projected increase in population of 8.8%, with demographic factors expected to drive demand for health care services in excess of that total.

Our Action Plan

A number of major changes are necessary to have a sufficient number of physicians to meet the anticipated demand in the future. These changes focus on:

- Enrolling students in medical schools who will practice in Wisconsin.
- Developing new care delivery models.
- Retaining physicians in and attracting physicians to Wisconsin.
- Targeting and enhancing funding for medical education.
- Creating an infrastructure to guide medical education in Wisconsin.

Goals and Action Steps

GOAL I: Recruit, enroll and train in Wisconsin's medical schools individuals who are likely to practice in Wisconsin, with particular attention towards underserved parts of Wisconsin.

Action Steps:

- Increase the number of students in medical school.
- Establish goals for medical schools to set and achieve targets for successful recruitment and retention of students from underserved areas.
- Create regional specialty training networks to expose trainees to underserved areas.
- Develop/replicate programs that attract to medical school, students most likely to practice in underserved areas.
- Create a programmatic focus or a "School within a School" to focus on underserved areas.
- Start promoting health careers at the middle school level.

GOAL II: Develop care delivery models that will enhance and leverage physician resources.

Action Steps:

- Provide funds for pilot projects demonstrating "team care models."
- Conduct pilots and studies of alternative delivery models.
- Prepare medical students and residents to work with advanced practice providers.
- Investigate potential mentoring opportunities using retired, part-time and administrative physicians.
- Evaluate shortening the timeframe for medical education.

GOAL III: Create policy and practice that encourages physicians to enter and remain in practice in Wisconsin. Create similar policies to encourage physicians to return to Wisconsin to practice.

Action Steps:

- Create funds for loan forgiveness for physicians to stay in the state after their residencies.
- Establish incentives to ensure specialists are adequately dispersed across the state.
- Identify and publish best practices for recruitment and retention.
- Maintain Wisconsin's favorable medical malpractice environment.
- Ensure adequate payment rates to support physician recruitment.
- Provide monetary incentives to address selection of locale and specialty.

GOAL IV: Provide for adequate and targeted funding for medical education.

Action Steps:

- Increase state funding for medical education.
- Increase Medicaid GME and tie increases to Task Force goals.

GOAL V: Develop an infrastructure to guide medical education policy in Wisconsin.

Action Steps:

- Create a Wisconsin advisory council to monitor, predict and recommend activities to maintain an adequate supply of physicians for Wisconsin.
- Create a process to maintain adequate data about physician supply and demand.

Conclusion

These goals and action steps require the efforts of Wisconsin's medical schools, the provider community and policy makers to enact changes in medical education and physician practice. If that work is successful, we can be assured that our future physician workforce will be able to provide needed services to all of Wisconsin's citizens.

Task Force Members

Sandra Anderson, President, St. Clare Hospital and Health Services, Baraboo, WI

Ed Bradley, Director of Business Development, St. Nicholas Hospital, Sheboygan, WI

Leo Brideau, President/CEO, Columbia St. Mary's, Inc., Milwaukee, WI

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Larry Pheifer, Executive Director, Wisconsin Academy of Family Physicians, Thiensville, WI

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Art Ross, III, MD, Director of Medical Education, Gundersen Lutheran, La Crosse, WI

Alan Schwartzstein, MD, Dean Health System, Madison, WI

Charles Shabino, MD, Chief Medical Officer, Community Health Care, Wausau, WI

Tim Size, Executive Director, Rural WI Health Cooperative, Sauk City, WI

Bobbe Teigen, CEO, Sauk Prairie Memorial Hospital, Prairie du Sac, WI

Paul Wertsch, MD, President, Wisconsin Medical Society, Madison, WI

Staff to the Task Force

George Quinn, Senior Vice President, Wisconsin Hospital Association, Madison, WI

Judy Warmuth, Vice President, Wisconsin Hospital Association, Madison, WI

Introduction

Early in 2003, Wisconsin Hospital Association staff began to hear from member hospitals that they were having increasing difficulties recruiting physicians. While many rural and inner city communities have struggled with this issue for years, the statewide nature of these reports created a new urgency. Information was shared at the WHA Rural Health Council and at the WHA Board of Directors, which led the Board to establish a Task Force on Wisconsin's Future Physician Workforce. WHA also discussed the issue with the Wisconsin Medical Society, resulting in their co-sponsorship of the Task Force. The charge to the Task Force was:

- Conduct a needs assessment to understand current and future physician supply and distribution issues.
- Identify factors that are impediments to meeting those needs.
- Find specific strategies that will help assure adequate future access to physicians for Wisconsin patients and communities.

The charge to the Task Force work plan included the following tasks:

- Understand the current supply of physicians in Wisconsin.
- Identify and understand issues relating to estimating physician demand.
- Estimate the current and future demand/need.
- Identify strategies for meeting the specific needs.

Members of the Task Force included representatives from physician practice groups, the Wisconsin Medical Society, the Wisconsin Academy of Family Physicians, hospitals and health systems, the medical schools in Wisconsin and others. Four meetings were held. Information and data shared represented a number of perspectives on the issue, and the Task Force spent considerable time evaluating the evidence and arriving at potential solutions to the problem.

This document is organized into the following sections:

- A summary of the existing physician workforce in Wisconsin.
- An assessment of whether the current supply is adequate to meet the needs of Wisconsin's citizens now.
- A projection of future demand for physician services.
- A summary of the structure of physician preparation in Wisconsin.
- Analysis and conclusions regarding the supply, demand and education structure.
- A plan for action to address the issues and problems.

Physicians in Wisconsin

A Snapshot of the Current Physician Workforce

In 2000 there were 9,533 physicians working in Wisconsin (*Health Counts in Wisconsin*, BHI, 2000). Compared to other states, Wisconsin's 184 physicians per 100,000 population ranked 26 among the states (HRSA, *State Health Workforce Profiles, 2000*).

Physicians are commonly grouped by specialty, either as *primary care physicians* (physicians whose practice is family medicine, internal medicine or pediatrics) account for 34% of the total or as *other specialists* (surgery, radiology, neurology, etc.). The physician workforce reflects other health care workforce demographics in that 29% of the physicians in Wisconsin are over 55 years of age.

Is the Current Supply Adequate for Today's Needs?

The question of whether there is an adequate supply of physicians should be analyzed along two dimensions – geographic distribution and specialty. In other words, two questions must be answered: "What population and what geographic region are we referring to?" and "Which type of physician specialty – primary or other – are we looking at?"

The question of physician availability is a complex one involving elements of geography, culture and financing. Within the scope of this paper, the focus is not on the various financing mechanisms for health care delivery. But geographic and cultural barriers remain as very important factors that can prevent access to care for many patients, which is the focus on this analysis.

It is important to note that there are distinct differences between rural and urban areas when analyzing access. For rural areas, the issue is largely, although not entirely, one of geographic distance. For residents of rural areas, it may be too time consuming to seek care. In urban areas, on the other hand, residents may be as close as a few blocks from a physician practice, but because of cultural barriers, do not access nearby physician services. In the analysis that follows, we will focus on both of these situations.

The following sources were used to provide a framework for our analysis:

- The American Medical Association 2002 physician data base.
- The 2000 Wisconsin Bureau of Health Information survey of physicians.
- 2000 census data.
- Research in the area of physician supply and demand.

Primary Care Physicians

In looking at the adequacy of primary care physicians, one could mistakenly conclude that based on statewide averages, Wisconsin's current supply is adequate. The number of primary physicians in 2000 was 68 per 100,000 population. That is above the national average of 59 per 100,000 and well within the range considered as reasonable. *However, the problem with drawing this conclusion is that it ignores the differences in distribution of primary care physicians among individual counties in Wisconsin.* The exhibit below highlights those differences.

County	Primary Physicians Per 100,000
Dane	115
Milwaukee	88
Waukesha	72
Jefferson	42
Iowa	27
Pierce	24
Statewide	68

Source: BHI Physician Survey, 2000

Wisconsin's 72 counties range from a low of 20 primary care physicians per 100,000 people in Florence County to a high of 463 per 100,000 in Wood County (BHI *2000 Survey of Physicians*, WHA analysis). The median is 31 physicians per 100,000 population. *Thus, with respect to primary care physicians, Wisconsin appears to have a maldistribution problem, not one of total supply.*

The fact that there are disparities does not, by itself, prove that there is an insufficient supply in those counties at the low end of the distribution. A number of studies have been conducted that attempt to answer the question of "How many are sufficient?"

Donald Libby, PhD and David Kindig, MD, PhD, in their paper *"Estimates of Physicians Needed to Supply Underserved Americans Adequately until Universal Coverage,"* used an *"expert average"* approach to determining the adequate number of primary physicians, by geographic area. They surveyed a number of researchers who study issues related to the physician workforce and arrived at a consensus number per 100,000 population. The geographic areas were defined around population concentrations.

The resulting matrix is displayed below. It should be noted that this study did not intend to say what was needed but what might be reasonably achievable under current conditions; obviously advocates for rural communities would argue (as the national *Council On Graduate Medical Education* [COGME] has done) that these "expert averages" are too low for rural communities.

Type of County	"Expert Average" Recommendation per 100,000
Metro Core	72
Metro Fringe	58
Small City	72
Rural	55
Sparse	51

The *"Metro Core"* geographic unit is further subdivided between areas that include urban shortage areas and those that do not. Urban shortage areas are geographic areas, often very small, that have been defined by the Bureau of Primary Health Care, an agency of the Health Resource and Services Administration, as being medically underserved. Using this construct, WHA compared the number of primary care physicians in each geographic unit to the recommended levels. The results are displayed in the table below.

Geographic Unit	Primary Physicians	2000 Population	Primary Physicians per 100,000	Recommended Average per 100,000	Unmet Need for Primary Physicians
Metro Core	1,137	1,383,248	82	72	77
Metro Fringe	500	943,626	53	58	110
Small City	1,426	1,890,031	75	72	205
Rural	496	862,759	58	55	69
Sparse	114	284,011	40	51	45
Statewide	3,674	5,363,676	68	68	506

Source: 2000 BHI Physician Survey; WHA Analysis

Using the recommended average for primary physicians per 100,000 and applying that to the 2000 population in each of the categories above, this analysis suggests that *there is currently an unmet need for primary physicians in Wisconsin totaling 506*. Note that several geographic areas, in total, appear to have a surplus. Yet a deficit is indicated. This is because a deficit exists for certain counties within those areas, and it is assumed that primary care physicians in neighboring counties will not fill the deficit. While one could make an argument that patients could travel into counties with surpluses to seek primary medical care, this would deny the right of patients to have access to care in their own communities, and ignores the circumstances of those unable to travel. While patients may travel outside of their community to seek specialized care, that is rarely the case for primary medical services. So we make the assumption that if a county shows a deficit, that deficit is valid regardless of whether it is adjacent to a county with a surplus.

With respect to the *"Metro Core"* area, the calculation shows *a deficit of 72 primary physicians in the medically underserved areas of Milwaukee County*. As stated above, access issues in urban areas are not necessarily related to distance. Other barriers, including income and ethnicity, often prevent access to care to residents in these areas. So even though the populations in the urban medically underserved areas may be quite close to concentrations of physicians, patients will not access that care.

Even though the overall statewide total appears to be sufficient, the distribution of physicians is skewed toward the urban (but not inner city) areas. The populations of the *"Metro Fringe," "Rural," "Sparse,"* and the medically underserved areas of the *"Metro Core"* units represent 45% of Wisconsin's population, while having only 35% of primary physicians.

Specialty Physicians

The methodology used to analyze the need for primary care physicians cannot be applied to specialists. There is no consensus evidenced in the literature on the number of specialists that are needed across a population. Instead, the need for specialists was determined using two sources of information:

- A recent national survey, conducted by Dr. Richard Cooper, of medical school deans and state medical societies.
- Information provided to WHA by The MHA Group, a physician recruitment firm regarding their national experience and in recruiting physicians for Wisconsin.

Cooper's survey, which was published in the December 10, 2003 issue of the *Journal of the American Medical Association*, received responses from 70 medical school deans and 44 state medical societies. Each group was asked to assess the status of the physician supply in their areas or states. In each case, more than 80% of respondents said that they thought there was a shortage of physicians. A summary of their responses is provided in the following table:

Table. Perceived Specialty Shortages and Surpluses of Physicians

	No. (%)			
	Medical Schools (n = 70)		Medical Societies (n = 44)	
	Shortages	Surpluses	Shortages	Surpluses
Anesthesiology	35 (50)	1 (1)	10 (23)	
Radiology	31 (44)		6 (14)	
Pathology	0		1 (2)	1 (2)
Family/general practice, general internal medicine, primary care	21 (30)	2 (3)	24 (54)	4 (9)
Pediatrics	5 (7)		2 (4)	
Pediatric subspecialties	8 (11)		3 (7)	
Obstetrics/gynecology	4 (6)		11 (25)	
Medical subspecialties	27 (39)	2 (3)	19 (43)	3 (7)
Cardiology	7 (10)		6 (14)	
Gastroenterology	9 (13)		6 (14)	
Geriatrics	8 (11)		0	
Pulmonary/critical care	3 (4)		3 (7)	
Dermatology	14 (20)		7 (16)	
Neurology	5 (7)		4 (9)	
Surgery (general/trauma)	12 (17)		6 (14)	
Surgery subspecialties	15 (21)		13 (30)	
Neurosurgery	8 (11)		3 (7)	
Orthopedic surgery	3 (4)		8 (18)	
Otolaryngology	3 (4)		1 (2)	
Urology	4 (4)	1 (1)	3 (7)	
Psychiatry	9 (13)		8 (18)	
Child psychiatry	3 (4)		2 (4)	
Emergency medicine	7 (10)		7 (16)	

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The two types of respondents differ regarding specialty, and the severity of the shortages is not indicated. However, in the opinion of those who are likely to have some knowledge about the supply of specialists, *there is a shortage in a number of specialty areas*.

The MHA Group provided WHA with the following results from their "2003 Physician Recruitment Trends" report, which is the product of an annual nationwide survey of hospitals and medical groups.

Specialties Rated "Very Difficult" to Recruit	
Radiologist	63%
Orthopedic Surgery	58%
Anesthesiologists	49%
Cardiologists	47%
Rheumatologists	46%
Urologists	42%
Dermatologists	41%

Source: MHA Group, 2003 Physician Recruitment Trends

In addition, The MHA Group shared their national experience regarding the number of physician search engagements that they have had over two time periods. The table below summarizes that comparison.

	Number of Searches in 1997/1998	Number of Searches in 2002/2003	Percent Change
Radiology	11	230	1991%
Orthopedic Surgery	76	191	151%
Cardiology	97	188	94%
Anesthesiology	9	134	1389%
Family Practice	585	122	Minus 79%
Internal Medicine	231	113	Minus 51%
Obstetrics/Gynecology	124	110	Minus 11%
General Surgery	21	84	300%
Gastroenterology	7	69	886%
Psychiatry	42	59	40%

Source: MHA Group, 2003

The first analysis is suggestive of a shortage across a number of specialties such as radiology and orthopedic surgery. The second reveals a shift away from searches for primary physicians in 1997/1998 and towards more specialists in 2002/2003; but also shows a dramatic increase in the number of searches for the ten specialties listed. Overall, searches for the top 10 specialties increased during that period by 8%.

Both of the MHA Group analyses provide a clear indication of the increased demand for specialty physicians. These results represent national totals. Wisconsin data is not available by specialty, but for the same periods, MHA searches for specialists in Wisconsin increased from 38 in 1997/1998 to 60 in 2002/2003, a 58% increase, indicating that at least in terms of using physician recruiting firms, Wisconsin activity greatly exceeded the national averages.

With regard to distribution of specialty physicians within Wisconsin, disparities exist that are similar to those with respect to primary care physicians. The table below compares physician totals per 100,000 for urban and rural areas of Wisconsin.

Geographic Unit	Specialty Physicians	Physicians per 100,000
Metro Core	2,232	152
Metro Fringe	770	90
Small City	2,594	137
Rural	451	49
Sparse	19	8
Statewide	6,066	113

Source: 2000 BHI Physician Survey; WHA Analysis

While the average for the entire state is 113 specialty physicians per 100,000, the range is quite wide: from a low of eight in the "*Sparse*" geographic unit to a high of 152 in "*Metro Core.*"

Foreign Born International Medical Graduates

The foreign born international medical graduates (IMG) provide access to care in underserved areas throughout the U.S. Just under a quarter of the nation's physicians are IMGs. They represent a similar percentage among physicians that admit to *Critical Access Hospitals.*

For Wisconsin, IMG physicians represent 16% of total physicians. They enter practice in underserved areas as part of the J1Visa Waiver Program. The *Wisconsin Office of Rural Health*, as part of a study of this program, found that these physicians are seen as good providers and work well with staff, but have more difficulty integrating into the community. Two thirds of these physicians were still at their original practice site after three years (the length of the J1 Visa Waiver Program), but this number dropped to 30% after six years. This is far less than non-IMG physicians.

In addition, the application of Homeland Security laws has created more barriers for these physicians to enter the U.S. Recent HHS regulations will also significantly reduce the number of underserved sites that will qualify for this program. IMGs have played an important role in providing access to health care in underserved areas; however, their overall numbers in Wisconsin are small, and regulatory changes will likely limit this further. Because of these considerations, the IMG component of the physician work force in Wisconsin is not one that has potential as a solution to the work force needs.

Conclusions Regarding Current Supply and Demand

The implications are that patients are increasingly waiting longer to receive care, traveling long distances for that care, or because of these and other barriers, are deciding to not seek necessary medical care.

An analysis of the current situation indicates an unmet need for both primary care and specialty physicians in Wisconsin, particularly in rural areas and in the inner city of Milwaukee. The implications are that patients are increasingly waiting longer to receive care, traveling long distances for that care, or because of these and other barriers, are deciding to not seek necessary medical care.

One illustration of the impact that lack of access to physician services causes is inappropriate emergency room utilization. WHA conducted a study of emergency room use in hospitals in Milwaukee County by the uninsured. In 2002, almost 36,000 emergency room visits were considered urgent or otherwise non-emergent. Most of these visits took place between the hours of 6 p.m. and 10 p.m. In addition to the substantial misallocation of resources this involves, this is evidence that needed primary medical care services are not being met in a timely or cost efficient way.

Lack of access to physician services causes inappropriate emergency room utilization.

What About Future Needs?

The Task Force was also charged with assessing the supply of, and demand for, physician services in the future. This is critical because of the long timeframe, a decade or longer, needed to train physicians. If it is determined that a physician shortage is likely to exist in the future, action must be taken now to begin to address that forecasted shortage.

Making predictions about the future is always fraught with risk. There are many factors that will affect the demand for physician services, most of which no one can forecast with any great degree of confidence. Consequently, the following approach was used:

- Identify factors that influence the supply of and demand for physician services.
- Assess the usefulness of each factor in the forecast.
- Arrive at a set of assumptions about how the remaining factors will change in the future.
- Calculate the supply and demand.

Factors That Influence the Demand for Physician Services

- Utilization patterns
- Population and demographic factors
- Payment for health care in the future - insurance/payment changes
- Technology
- Reduced need for health care because of better disease management

Factors That Influence the Supply of Physician Services

- Changes in graduate medical education (GME)
- Physician attitudes and cultural changes
- Changes in the delivery of care
- Technology
- Malpractice environment
- Government policies

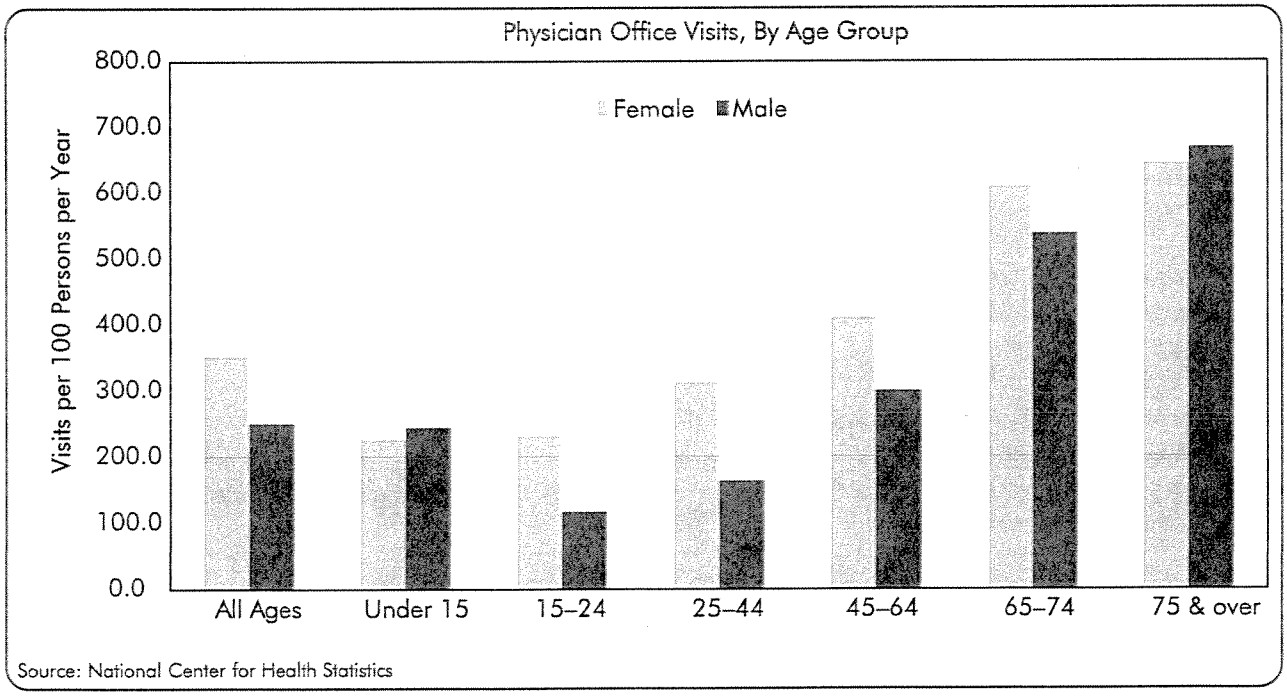
From the lists above, the population and demographic factors and utilization patterns were chosen as tools to project demand. To estimate the supply of physicians, Wisconsin's existing physician workforce was used as a baseline, with those expected to be trained and stay in Wisconsin and those from other states expected to enter practice in Wisconsin added in. Those expected to retire or otherwise leave practice were subtracted from the total. Also factored in was the expected impact of changes in physician work hours. All the other factors were found to be either lacking in adequate documentation or too speculative to project; or they were items that need to change, and therefore were more appropriately incorporated into the Task Force's recommendations.

Utilization Patterns

Age, gender and cultural factors have a significant influence on the use of physician services. In general, elderly patients and females consume a higher number of physician services than younger, male members of the population.

> Elderly patients and females experience a higher number of physician services than younger, male members of the population.

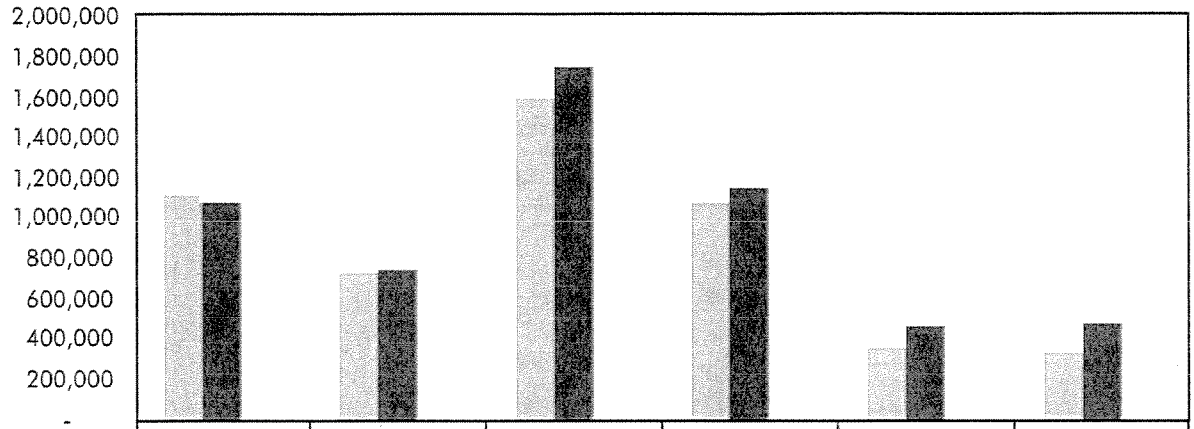
The chart below illustrates the magnitude of the difference for physician office visits. For example, a male aged 75 or older will, on average, have four times as many office visits as a male between the ages of 25 and 44. A female between the ages of 25 and 44 will have, on average, twice as many office visits as a male of the same age. It is not clear whether the relationships of office visit frequency among various population components will be the same in the future. Much speculation has been made about, for example, a healthier future elderly population lessening the need for as much health care services. That point is covered in Appendix A, but the Task Force concluded that predictions about that couldn't be made with any confidence. Therefore, the analysis assumed the same relative ratios of visits, as currently is the case.



Source: National Center for Health Statistics

Population and Demographic Factors

The U.S. Census Bureau has developed a forecast of Wisconsin's population in 2015 by age range. The chart below summarizes that forecast. One can observe that the populations in the "65 to 74" and "75 and over" age ranges are predicted to increase substantially.



	Under 15	15–24	25–44	45–64	65–74	75 & over
1998	1,110,730	736,150	1,598,650	1,081,320	358,230	331,310
Est 2015	1,078,713	749,084	1,752,798	1,154,253	468,374	473,126
% Change	-2.9%	1.8%	9.6%	6.7%	30.7%	42.8%

Source: U.S. Census Bureau; WHA Analysis

Projected Demand

Combining the existing ratio of visits by age category and the projected changes in demographics, one can project the number of visits. The table below shows that, while the total population is projected to increase by 8.8%, visits are projected to increase by 13.5%. This results from assuming that the current relationships for visits by age cohort hold true, combined with the increase in the percentage of the population having a higher frequency of visits.

Actual and Projected Office Visits

	1998 Actual	2015 Projected	Percent Change
Wisconsin Population	5,216,390	5,676,349	8.8%
Visits per 100	302.9	316.0	4.3%
Physician Visits	15,799,000	17,937,000	13.5%

Visits are considered to be a reasonable measure of demand for primary physicians. Without any further assumptions regarding changes in delivery of care, the conclusion is that there will be a double-digit increase in the demand for primary physicians.

The conclusion is that there will be a double-digit increase in the demand for office visits.

Demand for specialists will, to a large extent, also be driven by the change in population and demographics. But technology and its increasing availability and effectiveness for treating patients is at least as important in making such projections for specialists.

While much research has been done on this subject, the most recent work by Dr. David A. Etzioni, of the UCLA Medical School is noteworthy. Etzioni used a methodology similar to the one used above to project the demand for surgical procedures in 2010 and 2020. His data sources included the 1996 National Survey of Ambulatory Surgery and the National Hospital Discharge Survey, combined with the population forecasts from the U.S. Census Bureau.

Etzioni concluded that demand for surgery would increase by nearly 50% by the year 2020. Surgeries performed predominantly on older adults, such as cataract and heart surgery, will have the highest increase in demand. The following table summarizes his projections:

Projected Percent Increase in Surgeries Performed by Specialty

Specialty	2010	2020
Cardiothoracic Surgery	18%	41%
General Surgery	13%	28%
Neurosurgery	14%	27%
Ophthalmology	15%	47%
Orthopedic Surgery	13%	25%
Otolaryngology	6%	14%
Urology	14%	33%

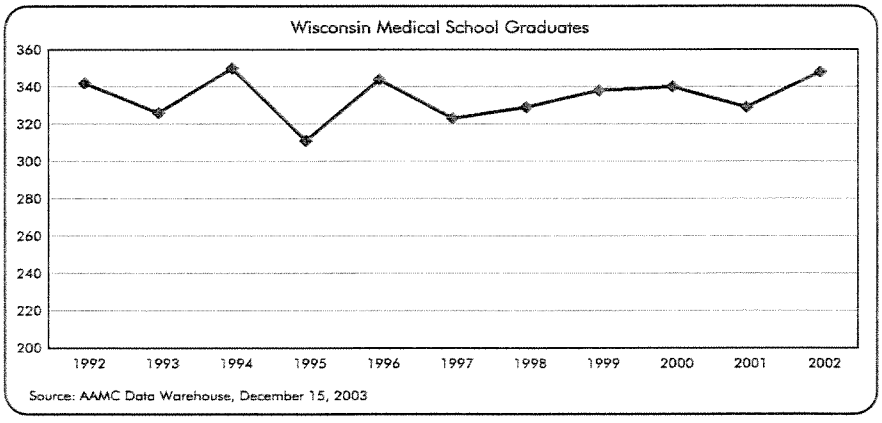
Source: David Etzioni, UCLA Medical School; WHA Analysis

While this study focused on surgery specialties, one can assume that the increase in surgical volume would result in an associated increase in demand for other specialists, such as radiologists and anesthesiologists. In summary, a reasonable conclusion is that the demand for most specialists will increase by double-digit percentages.

Supply of Physicians - Methodology

As stated above, the existing ratio of physicians per 100,000 people was used, and factored in were the number of physicians trained and retained in Wisconsin, expected retirements and number of physicians from other states entering practice into Wisconsin.

The first component of the above formula relates to the number of graduates from Wisconsin's medical schools. The total number of graduates from those schools has remained relatively constant for over a decade, as the following chart illustrates:

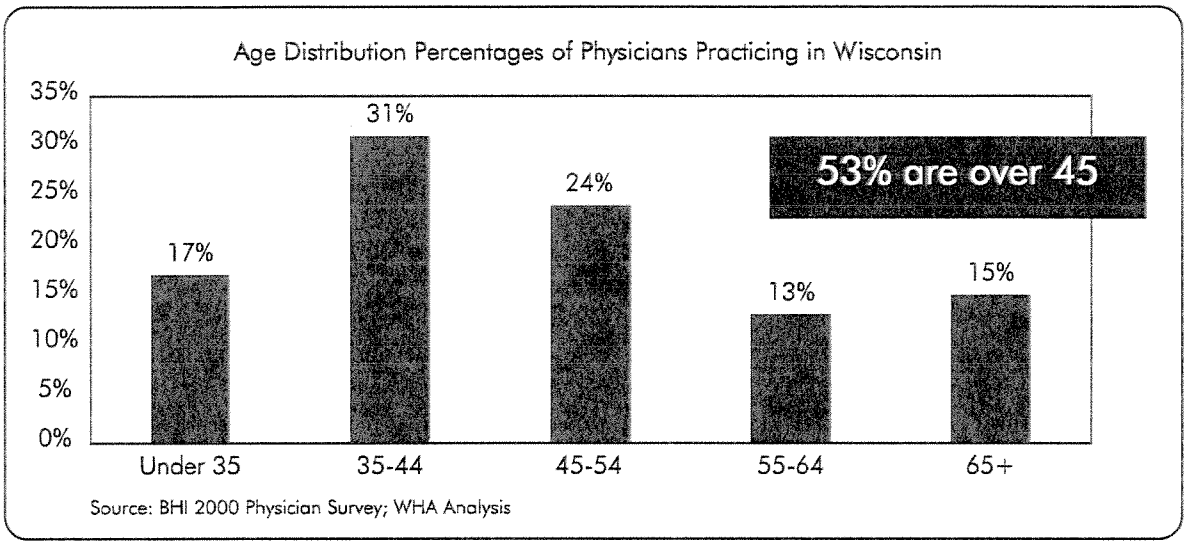


The chart shows that Wisconsin's medical schools have graduated between 325 and 350 students per year. Historically, about 38% of Wisconsin's medical school students are retained and practicing in Wisconsin. This would imply that between 125 and 133 per year would be practicing in Wisconsin, resulting in an additional 1,500 to 1,600 physicians by 2015.

Historically, about 38% of Wisconsin's medical school students are retained and practicing in Wisconsin.

Incoming physicians are defined as those who choose to practice in Wisconsin but neither attended a Wisconsin Medical School, nor did a residency in Wisconsin. Wisconsin Medical Society information and the last ten years of data from the Wisconsin Department of Regulation and Licensing on newly licensed physicians was used to calculate the number of physicians coming into Wisconsin.

Physician retirement represents the largest component of expected reductions in Wisconsin's physician workforce. To calculate the expected number of retirements per year over the next 10 years, the age demographics of the currently available data were analyzed. The following chart provides an analysis of the age distribution of physicians practicing in Wisconsin in the year 2000.



The chart indicates that 28%, or 2,660, of the 9,533 physicians currently licensed in Wisconsin will either retire or significantly reduce their practices within the next 10 to 12 years. This timeframe is within the prediction horizon of 2015.

Another emerging factor that will have an impact on the available workforce relates to cultural demographic factors within the physician workforce. Survey results and anecdotal comments from health care recruiters are pointing towards a desire on the part of recent medical school graduates for fewer practice hours, and an expression of a greater emphasis on family life. Further, research by Cooper and others indicates that physicians entering the workforce today are choosing lifestyles that devote less time to medical practice and more balance with family and personal activities. Based on the admittedly limited data at this point, the Task Forces estimates that, by 2015, this phenomenon will have the effect of reducing the "raw count" of physicians by a minimum of 2%.

Physicians entering the workforce today are choosing lifestyles that devote less time to medical practice and more balance with family and personal activities.

Projected Supply of Physicians in 2015

In summation, this study projects that the Wisconsin physician workforce for 2015 results from the summing of the current workforce; adds future graduates from Wisconsin medical schools who are anticipated to stay in the state, as well as those from other states who are expected to enter practice in Wisconsin, subtracts retiring physicians and applies an FTE reduction factor to estimate the effect of a growing pretence for lifestyle balance.

The following table provides a summary of the projection.

	Low Estimate	High Estimate
Currently licensed in Wisconsin	9,533	9,533
Physicians produced by Wisconsin medical schools	1,500	1,600
Physicians from other states obtaining Wisconsin license	1,050	1,800
Retiring physicians	(2,660)	(2,660)
FTE reduction factor (2% of total)	(190)	(205)
Projected total for 2015	9,283	10,068

The projections range from a slight decrease of 2.6% to an increase of 5.6% in the number of physicians. *In either case, the projections indicate a shortage overall compared to the projected double-digit percentage increases in demand.* There is insufficient data to segment the projections by primary versus specialty physicians.

Physician Preparation

The standard track for medical education in the United States starts with baccalaureate preparation for the study of medicine, followed by a university-based medical school, finishing with direct clinical experience as part of medical education (referred to as a residency). The total number of years for physician preparation under this model ranges from 11 years for generalists to 15 years or more for specialists. Physicians trained in Wisconsin's medical schools follow this structure.

Medical Education in Wisconsin

Medical schools in Wisconsin graduated 348 new physicians in 2002. Wisconsin has traditionally ranked higher than average in the number of medical school graduates. In 1997, Wisconsin ranked 19 among the 46 states with medical schools in the number of graduates. On a per capita basis, Wisconsin graduated 6.4 new physicians per 100,000 population, comparable to the national average of 6.6 and ranked 20 among the 46 states in medical school graduates per capita. Overall, approximately 38% of medical students who have attended one of the two schools in Wisconsin are practicing in Wisconsin.

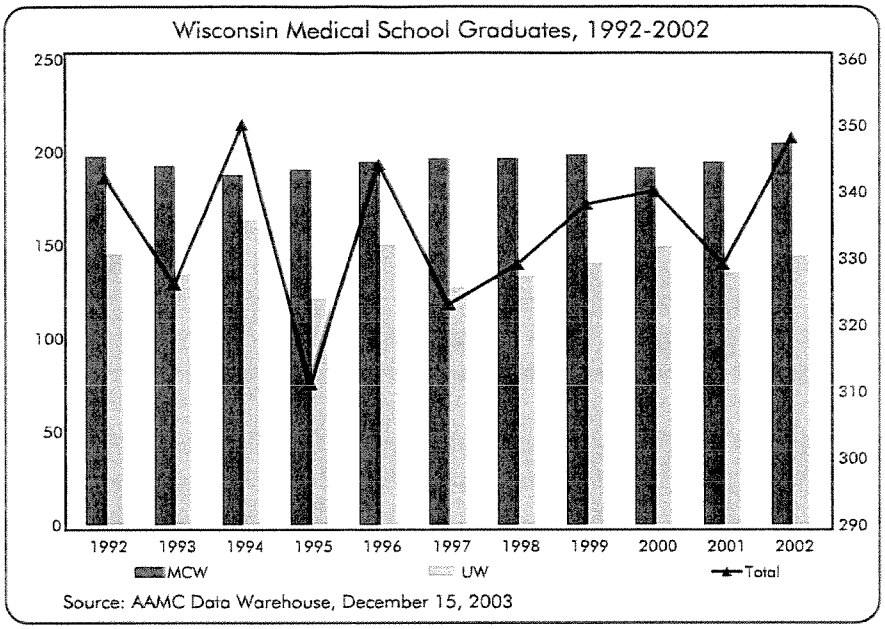
Wisconsin's Medical Schools

The state of Wisconsin has two medical schools: The University of Wisconsin-Madison School of Medicine (UW), and The Medical College of Wisconsin (MCW).

The UW Medical School opened in 1907 as a two-year program. The school averages about 550 medical students and graduates approximately 138 each year. Approximately 17% of physicians practicing in Wisconsin are graduates of the University of Wisconsin Medical School.

The Medical College of Wisconsin is located in Milwaukee. While it is a private academic institution, it has received significant federal and state assistance over the years. MCW began in 1893 as the Wisconsin College of Physicians and Surgeons, in 1913 it became the Marquette Medical School and in 1967 it became a freestanding institution. The school averages about 780 medical students and graduates, on average, 197 students each year. Approximately 17% of Wisconsin physicians are graduates of the Medical College of Wisconsin or its antecedent institutions.

The chart below provides an overview of graduates for the period 1992 through 2002.



Residency Programs

Wisconsin had more than 1,400 allopathic physicians in training (residents) in 1999 and ranked 21 among states in the number of allopathic residents. On a per capita basis, Wisconsin ranked 23 among states, with 27.5 residents per 100,000, lower than the national average of 35.9. Between 1989 and 1999, the number of residents per capita in Wisconsin grew by 6.4%, higher than the national increase of 3.9%.

There are 153 residency programs available in Wisconsin. For the 1999/2000 school year, there were 1,443 physician residents.

Of the 153 residency programs, there are 12 family practice programs. Two of the 12 are focused on inner city programs with 12 slots, while five offer rural fellowships or training tracks, having a total of 24 slots.

Analysis and Conclusions

Conclusions Regarding Supply of Physicians

The analysis shows a deficit of physicians, both for current needs and for the anticipated demand for services in the future. To summarize, the current supply is not sufficient along two dimensions:

- There is a shortage of primary physicians in rural Wisconsin and inner city Milwaukee.
- In general, specialty physicians are in demand and hard to recruit on a statewide basis.

For the projected year of 2015, it is anticipated that the demand for physicians will grow:

- By at least 13.5% for primary physicians over and above current shortages.
- At rates in the high teens to a low 20% range for specialists.
- Overall, we can conclude that there will be a significant increase in demand.

The change in physician supply is projected to be between a 2.6% decrease and a 5.6% increase.

The change in physician supply is projected to be between a 2.6% decrease and a 5.6% increase. This compares to a projected increase in population of 8.8%, with demographic factors expected to drive demand for health care services in excess of that total.

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The projected supply is expected to lag the demand in either of the supply projection scenarios, both of which the Task Force considered to be conservative.

Observations on the Current Medical Education Structure

While the medical schools in Wisconsin graduate and train a substantial number of physicians, fewer than 40% of those trained practice in the state. Furthermore, the programs that are currently in place to address underserved populations, the rural and inner city residency programs, have not supplied enough physicians to meet the demand. As indicated above, there is currently a shortage in rural areas of over 400 primary physicians and in the inner city areas of Milwaukee, the shortage is calculated at 72 primary physicians. Yet there are only 24 residency slots targeted at serving rural areas, and 12 that focus on the inner city.

Based on the needs that have been identified, it is unlikely that these programs, as currently constituted, will ever produce the required number of physicians for rural or inner city areas. A fundamental reassessment and potentially a restructuring of the state's medical education institutions will be necessary.

Other Factors That Need to Change in Order to Meet the Anticipated Demand

Increasing the production of physicians by Wisconsin's medical schools will not, by itself, solve the physician shortage problem. It would be difficult for our medical schools to increase the numbers rapidly enough to keep up with the increasing demand. Stakeholders need to consider other factors that would enhance the ability of Wisconsin's citizens to access physician services. The Task Force considered two such factors:

- *Develop strategies to attract physicians currently practicing elsewhere.*

  Obviously, there is a supply of physicians outside the state of Wisconsin. If Wisconsin implemented strategies to market the advantages of practicing in Wisconsin, the physician supply could increase in a more timely way than if producing physicians relied solely through the medical education establishment. Caution is in order here, however, because there is growing evidence of a significant national physician shortage. Redistributing physicians among the states merely shifts the supply problem.

- *Evaluate the current system of care delivery to identify whether there are ways to leverage and enhance the existing complement of physicians.*

  Currently, the methods for delivering services relies on physicians, supplemented with nursing personnel, making one-on-one contacts with patients, making assessments regarding diagnosis, and developing and implementing treatment plans. This model relies heavily on the physician, and if left unchanged, will do nothing to solve the physician shortage issue.

A number of health care systems have been using innovative approaches to provide care to more patients with the same number of providers.

Wisconsin should analyze current delivery systems to identify ways in which changes could help leverage the existing base of physicians to provide more care. A number of health care systems have been using innovative approaches to provide care to more patients with the same number of providers. Stakeholders should study these methods for their potential in improving supply.

In addition, attention needs to be given to the possibility of making available and using a greater number of other health care providers, including physician assistants and nurse practitioners. These providers could provide many of the services currently provided to patients by physicians. Moreover, the educational and training timeframe to adequately prepare them is significantly less than it is for physicians. However, it needs to be recognized that a number of barriers, including patient expectations, physician culture and licensing requirements, would have to be overcome in order for this solution to be viable.

A Plan for Action

A number of major changes are necessary in order to have a sufficient number of physicians to meet the anticipated demand in the future. These changes focus on:

- Enrolling students in medical schools who will practice in Wisconsin.
- Developing new care delivery models.
- Retaining physicians in and attracting physicians to Wisconsin.
- Targeting and enhancing funding for medical education.
- Creating an infrastructure to guide medical education in Wisconsin.

The changes would affect Wisconsin's medical schools, the provider community as a whole, and the ways in which the state finances medical education and physician practice. The Task Force identified five major goals that address the major objectives outlined above.

Goals and Action Steps

GOAL I: Recruit, enroll and train in Wisconsin's medical schools individuals who are likely to practice in Wisconsin, with particular attention towards underserved parts of Wisconsin. This recommendation would require Wisconsin's medical schools to both increase the number of students, and to structure the recruitment and admission process to assure that students from underserved areas and students with an expressed interest in working in such areas would constitute a significant portion of each class.

Responsibility: Schools of Medicine, health care providers

Action Steps:

- Increase the number of students in medical school.
- Establish goals for medical schools to set and achieve targets for successful recruitment and retention of students from underserved areas.
- Create regional specialty training networks to expose trainees to underserved areas.
- Develop/replicate programs that attract, to medical school, students most likely to practice in underserved areas.
- Create a programmatic focus or a "School within a School" to focus on underserved areas.
- Start promoting health careers at the middle school level.

GOAL II: Develop care delivery models that will enhance and leverage physician resources. This recommendation would include researching and developing new care delivery models, including, for example: new teaching methods to expose students to teams of care, working with advanced practice providers and utilizing distance-learning methods for practitioners in isolated locations. It would also set the expectation that teaching/ learning would be conducted in areas where physicians would be expected to practice.

Responsibility: Schools of Medicine, hospitals and medical groups

Action Steps:

- Provide funds for pilot projects demonstrating "team care models."
- Conduct pilots and studies of alternative delivery models.
- Prepare medical students and residents to work with advanced practice providers.
- Investigate potential mentoring opportunities involving retired, part-time and administrative physicians.
- Evaluate shortening the timeframe for medical education.

GOAL III: Create policy and practice that encourages physicians to enter and remain in practice in Wisconsin. Create similar policies to encourage physicians to return to Wisconsin to practice. This recommendation would create incentives to practice in targeted areas and specialties.

Responsibility: Policy makers, funding sources, employing organizations

Action Steps:

- Create funds for loan forgiveness for physicians to stay in Wisconsin after their residencies.
- Establish incentives to ensure specialists are adequately dispersed across the state.
- Identify and publish best practices for recruitment and retention.
- Maintain Wisconsin's favorable medical malpractice environment.
- Ensure adequate payment rates to support physician recruitment.
- Provide monetary incentives to address selection of locale and specialty.

GOAL IV: Provide adequate and targeted funding for medical education. Current funding for residency programs is inadequate to cover true costs. Furthermore, no specific targeted funding is made available. This recommendation would focus on federal and state sources to fund resident education.

Responsibility: Federal policy makers, state policy makers, medical schools

Action Steps:

- Increase state funding for medical education.
- Increase Medicaid GME and tie increases to Task Force goals.

GOAL V: Develop an infrastructure to guide medical education policy in Wisconsin. The state of Wisconsin does not have a plan for identifying the numbers and specialties of physicians necessary to provide services to its citizens. In addition, it does not have the means to monitor and adjust any plan. This goal establishes an infrastructure to guide and monitor policy for medical education in Wisconsin.

Responsibility: Health care providers, medical schools

Action Steps:

- Create a Wisconsin advisory council to monitor, predict and recommend activities to maintain an adequate supply of physicians for Wisconsin.
- Create a process to maintain adequate data about:
  - Demographics.
  - Practice patterns and specialties.
  - Practice components such as call schedules and referral patterns or retirement plans.
  - Tracking physicians to identify where they are practicing – Wisconsin or elsewhere.
  - Students who graduated from Wisconsin high schools, who attended Wisconsin Medical Schools, and whether they did their residencies in Wisconsin, and their current location of practice.
  - Data on where physicians who graduated from Wisconsin medical schools are practicing at present. If not practicing in Wisconsin, recruit them back.
  - Medical school applications, acceptances and graduations for zip code of origin to determine if students from underserved areas are making it into the system.
  - Determine actual number of years in practice. This could be useful in answering questions about whether physicians are planning to retire at certain intervals.

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Appendix A

Factors Influencing Future Physician Supply and Demand But Not Considered in Making Projections

Payment for Health care in the Future - Insurance/payer Changes
In many ways, the ability to obtain medical care is a factor of whether one has insurance and what that insurance covers. Today in Wisconsin there are people without medical insurance. Should a program be created which provides coverage for all, demand for particularly primary care could change. Conversely, if benefit levels drop and/or coverage changes dramatically, consumers might reduce their utilization of health care resources. An example of such a change would be broad implementation of defined contribution plans. While there currently is a movement on the part of employers to reduce benefits or implement defined contribution plans, one cannot predict whether this will be a long term phenomenon, nor what impact there will be on utilization.

Cultural Changes in Practice Time Commitment
The number of hours a physician spends in medical practice varies. There is increasing evidence that physicians in general are reducing the amount of time spent in their practice and thus their productivity. Female practitioners, on average, spend fewer hours in practice; and recruiters report a greater emphasis on family life, time off and reduced call schedules being important to new physicians entering employment. The lifestyle changes are a relatively recent development, and not enough data has been generated to provide an adequate basis for prediction.

Technology
New devices, procedures, hardware and software are announced in the public and professional press every day. The impact of these devices on practice varies widely and while some innovations may reduce the time and effort previously dedicated to a procedure or administrative task, others will increase the amount of services delivered by making new services and procedures available.

Reduced Need for Health care Because of Better Disease Management
Recent news reports have suggested that the next wave of 'older' patients will be in better health that today's population. It has been proposed that today's adult is more likely to exercise, monitor fat intake and less likely to smoke. Many believe that we are more health conscious and will use fewer resources as we age. If this is the case, people are more likely to live longer, but have a lower level of utilization during the aging years.

Shift to Advanced Practice Providers in Different Ratio Than Today
Many Wisconsin physician practices utilize advanced practice providers (APPs). This is true for both primary care practices and specialist practices. These providers also deliver care in urgent care settings. Preparation time for this level of practitioner is shorter than for a physician and the patient response to care provided by nurse practitioners and physician assistants is positive. Current reimbursement and scope of practice issues place limits on these practices. Changes in either would make a difference in the number of advanced practice providers used in Wisconsin.

Demographic/Cultural Changes
The cultural face of Wisconsin is changing. There is a significant Latino population; additionally there is a significant Hmong population and hospitals in the state report additional new cultural and ethnic populations. This may impact physician supply and utilization.

Malpractice Environment
The cost of medical malpractice insurance and the degree of physician liability may influence where physicians locate or relocate. Professional journals contain stories of individual physicians moving their practices to Wisconsin because of current protections offered here. Significant in-migration of physicians would change the supply side. Other states passing legislation to offer similar protections is as likely a scenario.

Appendix B

What Works: A Compendium of Methods and Programs to Address Physician Shortages in Use in Other States

WHA staff collected examples of how states have addressed their rural physician supply problems. We felt that these approaches might be useful references for the Task Force as it developed its recommendations for addressing Wisconsin's physician workforce issues.

Iowa

The Iowa Health Professions Inventory (IHPI) is a computer-based tracking system that contains demographic, educational and professional information on every active Iowa health practitioner in selected professions (physicians, nurse practitioners, physician assistants, dentists and pharmacists). The 31-year-old tracking system allows the state to have "real time" data about both the supply of and demand for health professionals in the state. For example, if a physician moves into the state, retires or changes office location, the information is captured in the database almost immediately. To do this, program staff collects information from many sources-membership rosters at the state's medical and professional organizations, reports from hospitals on staff changes, news clippings and word of mouth, among other sources-and continuously update the database. In addition, they track the number of job openings for health professionals across the state.

According to Roger Tracy, assistant dean at the University of Iowa Medical College where the IHPI was first developed and is now maintained, this tracking system enables the state to do several things: 1) characterize its health workforce in "real time;" 2) monitor workforce trends (age, supply, demand, etc.); 3) provide support and justification for new workforce initiatives, such as recruitment and retention programs; 4) evaluate existing workforce programs; and 5) conduct research that results in policy changes. In the future, Tracy hopes to expand IHPI to include registered nurses.

Pennsylvania

Uneven geographical distribution of health care professionals is a major challenge for states, and shortages of physicians in rural areas is a persistent occurrence. Several medical school programs are taking the lead to increase the number of rural physicians by selectively admitting students who come from rural areas in the belief that they will return to practice in those areas. The Physician Shortage Area Program (PSAP) at Jefferson Medical College of Thomas Jefferson University in Philadelphia, Pennsylvania, has been doing this for 25 years with great success. According to the PSAP's comprehensive tracking data, 87 percent of PSAP graduates were practicing rural family medicine 5-10 years after they first located in practice. In addition, PSAP graduates account for 21 percent of rural family physicians practicing in Pennsylvania who graduated from an in-state medical school, even though they represent only one percent of all graduates from the state's medical schools.

The program recruits and then selectively admits students who have grown up in rural areas or small towns and who intend to return to a similar rural area to practice family medicine. Once admitted, students are paired with advisors in the Department of Family Medicine and are provided with financial aid. During their first two years of medical school, PSAP students meet with these advisors several times and are given the opportunity to participate in summer research in family medicine. During their third and fourth years, PSAP students are required to complete their clerkships and subinternships in rural or small town family practice centers. Following graduation, PSAP participants are expected to complete rural family medicine residencies.

The PSAP program began in 1974. It admits about 15 students a year. According to Howard K. Rabinowitz, MD, Professor of Family Medicine at Jefferson Medical College and Director of the PSAP since 1976, the program recruits students who have grown up in a rural area and who are committed to practicing family medicine in the same or similar area. PSAP students follow a curriculum similar to their non-PSAP classmates, but take some courses that focus on practicing family medicine in a rural community, receive training in rural or small town areas and pair with an academic advisor from Jefferson's family medicine department. Overall, PSAP graduates were eight times more all kinds of practice settings and geographic locations — from remote rural towns to suburban settings to major urban hospitals to inner city clinics. Further information about the School of Medicine curriculum, including

curriculum at WWAMI sites, is available.

Participating universities besides the University of Washington are: University of Alaska (UAA), Washington State University (WSU), University of Idaho (UI), and Montana State University (MSU). In 1988, the UI and WSU programs were combined under a single directorship. The University of Wyoming (UWy) joined in 1996 (modifying the acronym to WWAMI).

A Collaborative Success

The success of the WWAMI program has depended on the cooperation and partnership of many different parties in each state — state legislatures, state and local medical associations, hospital associations, higher education boards, colleges and universities, and, above all, faculty and community physicians from those states. That cooperation and partnership has become a trademark of the program. WWAMI works thanks to the efforts of thousands of committed individuals throughout the region.

Special Programs For Medical Students

Special experiences to encourage medical students to learn about and consider rural medicine have developed through the WWAMI program over the years. The Rural/Underserved Opportunities Program (R/UOP) provides early exposure for medical students to medical care in rural and urban underserved environments. The R/UOP program has received generous financial and organizational assistance from the Area Health Education Centers (AHEC), Washington Academy of Family Physicians, the Hearst Foundation, and many other individuals, communities, and organizations. The WRITE program offers a six-month clinical experience in a rural community for some medical students during their third year of medical school.

Medical students from the University of Washington can complete all of their third-year clinical clerkship requirements in Spokane, WA and Boise, ID. The "tracks" are coordinated through the Regional Medical Education Offices in Spokane and Boise. A similar experience in Anchorage is being developed.

Associated Programs

In addition to education for medical students, the WWAMI program focuses on a number of other areas: encouraging K-12 students from underserved areas to consider health careers; developing residency programs throughout the region; providing continuing medical education and consultations for physicians who practice throughout the region; and developing methods to enhance and improve health infrastructures in underserved communities. Programs like the Area Health Education Center (AHEC) Network serve a number of functions. Although not all of the described programs are directly part of the WWAMI program, all of them have grown out of the regional emphasis initiated by the program.

An Integral Part of the Medical School

The University of Washington School of Medicine is proud of the WWAMI program. The program serves as a constant reminder to faculty and students that service to and working with one's community provide rewards and immeasurable gains for all involved.

Just as the WWAMI program has benefited the region, so has the region benefited the medical school. WWAMI believes their medical students receive an education second to none, and a substantial portion of that success is due to the WWAMI program. Graduating classes consistently rank the diversity of the regional clinical training opportunities as one of the School's great strengths.

Michigan

Rural Physician Program (RPP): A Rural Clinical Experience

The Rural Physician Program (also known as the U.P. Program) is the College of Human Medicine's rural education program. Each year, eight College of Human Medicine applicants are selected to their clinical years in Michigan's Upper Peninsula. Preference for this program is given, though not limited to, applicants who have had significant experiences in rural Michigan or are considering eventually practicing in a small-town setting.

The Rural Physician Program Application Process

Physician shortages exist in Michigan's rural areas, and it is a goal of CHM to educate physicians who will practice

there. All applicants who receive a CHM Secondary Application are invited to apply to the RPP by submitting two essays outlining their interests in rural medicine and highlighting their personal characteristics and experiences that are consistent with becoming an excellent rural physician. RPP applicants should have interests and personality traits consistent with living in a smaller community and practicing in underserved, rural areas.

Program Description
The College of Human Medicine's mission is explicit about educating excellent, caring physicians who will practice in Michigan's underserved rural communities. The Rural Physician Program is a highly competitive program designed to educate students to become exemplary physicians with the clinical skills needed to meet the needs of rural Michigan.

The College of Human Medicine is a community-integrated medical school. Years 1 and 2, the preclinical years, take place at the Michigan State University East Lansing campus. Years 3 and 4, the clinical years, take place at one of six community campuses: Flint, Grand Rapids, Kalamazoo, Lansing, Saginaw and the RPP campus located in the Upper Peninsula (Marquette).

Each year, eight CHM admitted students are selected for the RPP, a clinical option for students whose goals include becoming able to *serve the people* in small towns and rural communities. The goal of the RPP is to provide students with enriched clinical experiences, community service opportunities, and small town lifestyle advantages that will encourage CHM Rural Physician Program alumni to establish rewarding practices in Michigan's rural communities.

RPP students receive an excellent clinical education from Michigan State University faculty and from CHM selected board certified volunteer physicians from the local community. Students also have the opportunity to work with the Family Practice Residents at Marquette General Hospital.

While the RPP was particularly designed for students entering primary care fields, graduates can and have gone into nearly all specialties. In keeping with the very successful Upper Peninsula (U.P.) Program that was established in 1974, the RPP curriculum emphasizes the caring, compassionate, humane approach to the doctor-patient relationship. Administered by the Upper Peninsula Health Education Corporation, the RPP provides students with outstanding, state-of-the-art facilities while maintaining a humanistic, personalized approach.

Rural Physician Program Block III (Years 3 and 4)
As a community-integrated medical school, CHM is uniquely positioned to provide students with comprehensive training in clinical settings that most closely parallel the type of environment in which many physicians will ultimately practice. All CHM students who successfully complete Block I (Year 1), Block II (Year 2), and Step 1 of the United States Medical Licensure Exam (USMLE) advance to Block III (Years 3 and 4), the community-based, clinical experience. Block III is an 80-week curriculum block comprised of physician-supervised required clerkships in family practice, internal medicine, pediatrics, obstetrics and gynecology, psychiatry, and surgery. These experiences take place in a variety of hospital and ambulatory settings. Advanced clerkships are required in surgery and internal medicine. Concurrent with clerkships, students participate in required weekly structured learning seminars on core interdisciplinary topics important to the care and health management of patients. Block III students also have four, four-week elective clerkships that may include an international experience.

After passing Step 1 of the USMLE, students who are accepted to the Rural Physician Program move to the Upper Peninsula for a challenging clinical experience. Students assume increasing responsibility for diagnosing and treating patients during their ambulatory care experience. A variety of outpatient settings, including schools and counseling programs, also enrich this ambulatory care experience. Additional opportunities for students to train at rural sites throughout the Upper Peninsula are continually being developed.

The core clinical disciplines are done at Marquette General Hospital, a 352-bed regional referral center with outstanding state-of-the-art facilities and dedicated physician educators. A hallmark of the program is the two-month Family Medicine clerkship in a small Upper Peninsula community, where one-on-one teaching and tremendous clinical exposure serves to coalesce prior learning and experience in a comprehensive, humanistic approach. Additional required and elective time can be done in Marquette, anywhere in the CHM system, nationally or internationally.

Applicant Qualifications

Competitive applicants to the College of Human Medicine M.D. program must have strong academic credentials, and personal attributes and career goals that are consistent with the CHM Mission.

Applicants to the Rural Physician Program must be admitted to CHM and have outstanding qualifications for practicing in a rural area, with consideration given for previous rural life experiences, initiative, and the desire to become not only excellent physicians but also community leaders. The RPP Admissions Selection Committee strives to accept students for RPP who reflect the diversity of the College of Human Medicine's entering class.

Illinois

Illinois ranks as one of the top states in the nation in terms of producing physicians, but it ranks fourth from the bottom for the number of residents living in areas underserved by primary care physicians. Of Illinois' 102 counties, 84 are considered rural by the Center for Rural Health of the Illinois Department of Public Health (IDPH). 75 of these 84 rural counties are designated underserved (using a primary care physician-to-population ratio of 1:2400 or greater in rural areas).

This lack of primary care physicians in less populated areas is a problem that the University of Illinois College of Medicine at Rockford has begun to address with its Rural Medical Education Program (RMED). RMED is designed to prepare students for the unique challenges that face rural physicians. The College of Medicine began matriculating students in the RMED program in August 1993. Students with roots and plans to practice in rural Illinois are encouraged to apply to RMED so they may participate in a special curricular experience designed to assist them in achieving their career goals.

Students meeting the qualifications of the University of Illinois College of Medicine are selected on the basis of evidence of their motivation for becoming a family physician, their desire to return to practice in rural Illinois, and their commitment to serve their communities. Selection involves a dual application process — submission of the regular AMCAS application with supplemental application to the University of Illinois College of Medicine and completion of the RMED application and interview. Fifteen students per year may be recommended for admission to the RMED program and the College of Medicine. Successful applicants must pledge to complete the RMED program, select a family practice residency program, and practice in rural Illinois.

The RMED undergraduate medical education curriculum will integrate with the regular curriculum of the College of Medicine at Rockford, which is noted for its 30 month longitudinal ambulatory primary care experience at the College's rural primary care centers.

The RMED curricular focus during the first two years is on *Foundations in Rural Family and Community Medicine I and II.* RMED students begin to develop an understanding of the core concepts of family medicine and the ways physicians can interact with their communities to affect both individual and community health. They are also exposed to a variety of rural health care topics, settings and providers.

The third year focuses on the interface between family medicine and the community. Students learn about the concepts involved in community-oriented primary care (COPC). They are also taught the skills necessary to design a community project, which will be implemented during their fourth year rural preceptorship.

The fourth-year students participate in a 16-week rural preceptorship experience, which is the capstone of the RMED curriculum. Hospitals and family physicians located in small, rural communities collaborate with the University of Illinois College of Medicine at Rockford to provide a unique educational and clinical experience for senior students. The preceptorship experience focuses on clinical skill development in a rural setting, the implementation of a community-oriented research or programming project, and a study of the rural community's social, economic, cultural, organizational and political structure. There are now 20 sites for this rural clerkship statewide. Curriculum and faculty development, site visits, and the use of telecommunications facilitate the development, monitoring and evaluation of this key educational experience.

Minnesota

University Minnesota Duluth School of Medicine Graduates:

- 53% practice family medicine, compared to 13 percent nationally
- 44% practice in communities smaller than 20,000 people
- 63% practice in Minnesota; 75% of graduates practice in Minnesota or Wisconsin

In the past 10 years, the University of Minnesota has graduated more than 8% of the nation's American Indian physicians, while providing less than 2% of the country's medical students.

School of Medicine Health Professionals Schooled to Serve Small Towns and the Rural Midwest

The University of Minnesota Duluth's School of Medicine is a nationally recognized two-year medical school program focused on training family practice physicians to practice in rural areas. Within the School of Medicine, the University's Rural Health School coordinates medical education and training for nurses, pharmacists, physician's assistants, social workers and advanced nurse practitioners. It is also recognized for its significant research in a number of areas with interests as diverse as molecular brain biochemistry, rural health issues, toxicology, aging, cancer and vascular disease.

Since its opening in 1972, the School has consistently led the nation in the percentage of its students choosing family practice as a career choice.

The School is affiliated with the University of Minnesota Medical School in Minneapolis where UMD students transfer to complete their third and fourth years of medical training.

Strong Local Support for Medical School Concept

The incentive for a school of medicine in Duluth began in 1966 when Samuel H. Boyer, a Duluth cardiologist, and then Assistant Provost Robert L. Heller discussed the need for a medical school through a chance meeting on a plane to Minneapolis from Duluth.

The idea for a medical school was developed through the efforts of a small group of local physicians, UMD administrators and faculty. Boyer assembled a group of leaders from the Duluth business and medical community to form the Northern Minnesota Council on Medical Education to lobby for the school and raise funds.

Eventually, the two-year Duluth medical school was approved in the face of competing proposals from St. Paul and Rochester. In 1969, the Minnesota Legislature appropriated $340,000 for planning.

Early Roots and Innovative Beginnings

The school was originally located on the Old Main campus in the former Laboratory School building at 2205 East Fifth Street. With Dr. Robert Carter as its first dean, the school accepted its first 24 students in the fall of 1972. That first year every medical student received a key to the school building, a tradition that continues today.

Two unique aspects of the medical school's curriculum have been the emphasis on the behavioral sciences and early exposure to patient care. A cornerstone of the school's training is the preceptorship program where a student lives with and shadows a rural family doctor several times a year. In 1990, the School received the prestigious National Rural Health Association's Outstanding Rural Health Program Award as a result of this program.

The School of Medicine moved to new facilities on the upper campus in 1979 near the science department area. The new building provided much needed expanded research facilities, which were designed with faculty input.

In 1987, the Center of American Indian and Minority Health was established to coordinate the various Indian programs administered throughout the School. Gerald Hill, MD, former president of the Association of American Indian Physicians, became the center's director in 1990. The school has always held a strong commitment to the recruitment and training of American Indian students as part of its mission to encourage and educate practitioners of rural medicine.

In 1997, the School of Medicine building was expanded with a four-level addition, which incorporated more student teaching space, a learning resource center and research facilities.

Definitions

Advanced Practice Providers - Non-physician providers of healthcare. This includes, but is not limited to, Physician's Assistants, Nurse Practitioners, and Nurse Midwives.

Council on Graduate Medical Education (COGME) - a body authorized by Congress in 1986 to provide an ongoing assessment of physician workforce trends, training issues and financing policies, and to recommend appropriate federal and private sector efforts to address identified. It is housed in the Division of Medicine and Dentistry; Bureau of Health Professions; Health Resources & Services Administration.

Critical Access Hospitals (CAH) - A federal category for rural hospitals with less that 25 beds that receive cost-based reimbursement from Medicare and Medicaid.

Expert Average - Methodology used by Libby and Kindig to determine physicians needed to supply underserved Americans. The methodology involved polling experts on physician supply using a structured data collection and using that data to create a population-based requirement estimate.

Foreign Born International Medical Graduate (IMG) - Physicians who were born and obtained their medical education in a country other than the United States.

Graduate Medical Education (GME) - Post MD medical training programs.

J-1 Visa Waiver Program - One way for graduates of foreign medical schools to enter the United States for further education is a J-1 Visa. Approximately 45% of IMG's who are not U.S. citizens or permanent residents, enter the U.S. on a J-1 Visa. A J-1 Visa allows six years in the U.S. and then requires a two year residence in the home country. It is possible to have that requirement waived. Providing care in a medically underserved area of the United States is one way to receive a J-1 Visa Waiver.

Metro Core (Counties) - Central counties in metropolitan areas that have a population of one million or greater.

Metro Fringe (Counties) - Fringe counties in metropolitan areas that have a population of one million or greater, or alternatively, non-metropolitan counties with an urban population of 20,000 or more adjacent to a metropolitan area.

Primary Care Physician - a physician who identifies his/her specialty as General Internal Medicine, General Pediatrics, Family Medicine, or General Practice.

Rural (Counties) - Non-metropolitan counties with an urban population between 2,500 and 20,000.

Small City (Counties) - Counties in metropolitan areas that have a population of fewer than one million, or alternatively, non-metropolitan counties with an urban population of 20,000 or more NOT adjacent to a metropolitan area.

Sparse (Counties) - Non-metropolitan counties with an urban population of fewer than 2,500.

Specialist - a physician who identifies his/her specialty as any specialty other than those listed for Primary Care Physician.

Team Care Models - Models of healthcare delivery in which a physician and one or more advanced practice providers in addition to other healthcare clinicians (such as Registered Nurses and Pharmacists) provide care to a patient or a group of patients.

Wisconsin Hospital Association - The Wisconsin Hospital Association represents more than 130 hospitals and health care systems across the state. WHA's mission is to advocate for the ability of its community-based hospital members to provide high quality, accessible and affordable health care services to Wisconsin communities.

Wisconsin Medical Society - The Wisconsin Medical Society, a trusted source for health policy leadership since 1841, is the largest association of medical doctors in the state with more than 10,000 members dedicated to the best interests of their patients.

Wisconsin Office of Rural Health - an office within the University of Wisconsin the purpose of which is to improve the quality of health for Wisconsin's rural and underserved communities by collaborating with health care, community and educational organizations to develop programs and provide resources.

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