Addressing Primary Care Physician Shortage is Key to Health Care Reform

By Keith Duncan, M.D. Ph.D.

President Obama has stated that one of his goals for health care reform is to make sure every American has access to a primary care physician. If that is truly the case, then immediate steps must be taken to address the increasing shortage of primary care physicians that we are experiencing locally and nationally. Without addressing this shortage, insurance coverage mandates and other reform efforts will fail.

According to a recent survey published in JAMA, only two percent of graduating medical students intend to work in internal medicine, five percent are going into family medicine and 12 percent are pursuing pediatrics. Researchers at the University of Missouri-Columbia and the U.S. Health Resources and Services Administration are also now projecting a family medicine and internal medicine physician shortage of 35,000 to 44,000 nationwide by 2025.

The primary care physician shortage is noteworthy in California and particularly in San Mateo County, which currently has a shortage of more than 50 primary care physicians, because of the high cost of living, low reimbursement rates from insurance companies and government programs such as Medicare and Medi-Cal, as well as the high cost of establishing a small independent practice. New families coming into our community or changing insurance coverage find most primary care physician offices are closed to new patients. For patients who can get an appointment, there are often long waits which can result in trips to the emergency room for care that would ideally be handled by their primary care physician. This situation will only get worse as many local primary care physicians are reaching retirement age in the next few years.

Recruitment Efforts Locally

At Mills-Peninsula, a high priority has been placed on the recruitment of primary care physicians to this community for the past several years. Economic assistance has been provided to 22 physicians, but unfortunately fewer than half remain locally and few of those remaining have flourishing independent practices. Other local hospitals, including Sequoia Hospital, which just launched a physician network, are also attempting to attract new primary care physicians.

Local examples of organizations that have been successful at recruiting...
Not only could a disability slow your pace… it might also stop your income.

According to the Insurance Information Institute (III, 2007), 43% of individuals between the ages of 40 and 65 will suffer from a long-term disability.

If you suffer a disabling injury or illness and can’t continue working, do you have a reliable financial source to help replace your income?

San Mateo County Medical Association members can turn to the SMCMA-sponsored Long Term Disability Insurance Plan.

This plan is designed to provide a monthly benefit of up to $10,000 if you become Totally Disabled. Members age 50–59 are eligible to apply for up to $6,000 per month.

Learn more about this valuable plan today. Call 800-842-3761 for free information. Or, download information and an application at: www.MarshAffinity.com/pages/cmadownload.html

Sponsored by: San Mateo County Medical Association

Underwritten by: Hartford Life and Accident Insurance Company, Simsbury, CT 06089. All benefits are subject to the terms and conditions of the policy. Policies underwritten by Hartford Life and Accident Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. (AGP-5719) • #CMA1-903

Administered by: Marsh

Hartford Life and Accident Insurance Company, Simsbury, CT 06089. All benefits are subject to the terms and conditions of the policy. Policies underwritten by Hartford Life and Accident Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. (AGP-5719) • #CMA1-903

DBA in CA: Seabury & Smith Insurance Program Management • CA License #0633005 • © 2008 Seabury & Smith Insurance Program Management 777 South Figueroa Street, Los Angeles, CA 90017 • 800-842-3761 • CAMCounty.Insurance@marsh.com • www.MarshAffinity.com • 12/08

Marsh is part of the family of MMC companies, including Kroll, Guy Carpenter, Mercer, and the Oliver Wyman Group (including Lippincott and NERA Economic Consulting).
Shortage of Physicians Leads to Decreasing Access

By Dirk Baumann, M.D.
SMOMA President

This issue of the Bulletin focuses on the growing shortage of physicians, primarily primary care physicians (PCP’s) within the US and particularly our County. While in California the number of active practicing physicians is nearly at the national average (245 versus 250/100,000 population), California has the highest percentage of active physicians age 60 and older (28%).

There is also increasing evidence that physicians are starting to leave the profession earlier due to increased hassles associated with managed care. From 2002 to 2015, California’s population over age 65 is expected to grow by 37%, and the population over the age of 85 is projected to increase by 38%. An aging population greatly increases the need for physician services – residents above age 75 need, on average, 5 times more physicians per 100,000 population than those under 17.

An aging population greatly increases the need for primary care physicians, and the current fee for service environment, medical subspecialties tend to be more lucrative. "Declining reimbursement" was the top reason given by practicing PCP’s as a hindrance to providing patient care, and 82% said their practices would be "unsustainable" if proposed cuts to Medicare reimbursement were made. In 2008, 65% of PCP’s said Medicaid reimbursement and 36% said Medicare reimbursement is less than their costs to provide care. The PCP lifestyle is often more demanding than other specialties, especially in rural areas where PCP’s tend to still maintain hospital as well as office practices. The development of hospitalist programs has allowed many younger physicians to choose a practice with more defined work hours. Finally, particularly in primary care, paper and administrative work in running a private practice is becoming more demanding. Non-clinical paperwork has caused 63% of PCP’s to spend less time with their patients, and 94% are spending more time with this non-clinical paperwork in the last three years.

However, patient relationships are what physicians find most satisfying about their practice.

While half of medical school seniors consider income and lifestyle as obstacles for entering a primary care practice, the main deterrent is the lack of positive role models or mentors. Morale amongst physicians and PCP’s specifically is low. The majority of PCP’s (60%) would not recommend medicine as a career to young people or their children. Only 6% of PCP’s described the professional morale of their colleagues as “positive”, while 42% of physicians said the professional morale of their colleagues is either “poor” or “very low”.

"Reimbursement issues" and “managed care issues” rated the highest on the list of issues physicians find unsatisfying about medicine. 78% of PCP’s said medicine is either “no longer rewarding” or “less rewarding”. From these statistics, it is little wonder that young students and physicians are not choosing primary care, and increased reimbursement will not likely improve the situation on its own.

Formation of Physician Groups

Recognizing the problem with the declining number of PCP’s in San Mateo County, physician leaders have evaluated ways to create a more stable physician community and are developing ways to bring about this goal. One way is through the formation of larger physician groups associated with foundations whose tax exempt status allows for the retention of assets to fund building and infrastructure, such as electronic health records, in the future. With declining reimbursement and increasing expenses, only 17% of physicians rated the financial position of their practices as “healthy and profitable” in 2008. Larger groups allow for economies of scale, improved contracting power, revenue from ancillary income, and redistribution of income across specialties based on need. In addition, they provide for superior coordinated care, better mentoring opportunities for young physicians, and less administrative responsibilities. Due to these advantages, the
larger groups in our community, e.g. Permanente Medical Group and Palo Alto Foundation Medical Group, have had enhanced success at physician recruitment than smaller private practices. As fewer physicians enter primary care (currently as low as 2% of all graduating US medical students), competition for these physicians will become fierce.

**Interest in General Surgery also down**

While primary care is a priority now, other specialties are also suffering. For example, general surgery programs have not filled their training slots for several years. Already, the number of general surgeons per capita has decreased by 25%, and general surgery is one of only a few specialties in which the absolute number of practitioners is declining. Like with primary care, reasons include demanding work hours, the long term of training programs and decreasing reimbursement as higher valued procedures are increasingly being done by subspecialists. In addition, since a large proportion of their work comes from the emergency room, the growing number of uninsured or underinsured patients impacts their revenues more severely. Forced with trying to provide for general surgery coverage for their emergency rooms, many community hospitals are resorting to hiring temporary general surgeons. General surgery is now among the fastest-growing areas of a temporary-medical-staffing industry that’s expected to double to $2.1 billion in 2009 from five years ago, according to Locumtenens.com, a staffing agency. Temporary employment opportunities offer defined work hours, no overhead, and limited administrative work. However, these are moneys taken away from patient care, hospitals and physicians. Medicine must find ways to entice intelligent young people into our profession again. Ω

In Perspective

By Leo van der Reis, M.D.

President Obama has indicated he intends to introduce measures that will bring about changes in the US health care delivery system, some similar to those that have been operational for decades in the developed democracies. Undoubtedly they will examine some of the non-US systems and the resulting experience with these systems.

An outstanding example of a national medical service program is the English National Health Service, enacted in 1946. Current conditions are by no means universally positive. There are ample complaints about poor service, poor facilities and difficult working conditions by physicians and nurses. The underlying problems today can be related directly to lack of financial support, investment in human and facility resources and education. In turn this is related to political policies and the overall economic situation of the country.

Two countries that have a comparable national health care coverage scheme, New Zealand and Israel, also experienced problems. Both countries originally had programs that were genuinely universal. However, the programs did not contain sufficient controls and resulted in excessive use and excessive costs. Both countries today still have extensive coverage, but have some limitations in terms of ease of access as well as individual financial responsibility.

The experience in New Zealand and Israel shows that in countries with rather small populations a mixture of private medical care financed through private employer combined with taxes and care provided in government facilities can provide top notch, up to date medicine. The majority of physicians combine practice in both public and private systems.

In many countries there is a position at high governmental level that is comparable to the US Surgeon-General. This individual, customarily a physician with clinical experience, is the physician-in-chief. He or she sets the tone for the public welfare in matters of medicine, whether it is disease prevention, well-baby care or the care of the elderly. However, unlike the US counterpart, this individual is customarily highly visible and expresses an independent personal, professional opinion. Within the scope of the reform measures contemplated by President Obama and his health care team, advantage should be taken of including the Surgeon-General in genuine problem-solving discussions.

It is noteworthy that comprehensive changes in medical care in all these countries came about through pressures from the voters on their parliamentary representatives and in spite of passive and active resistance by the medical profession. That resistance should not be a surprise; it is not so many years ago that organizations based on new health care delivery models such as Kaiser-Permanente were seen as unwelcome intruders. Ω
Physician Workforce Recount

By Sue U. Malone
SMCMA Executive Director

You may recall that in 2001 UCSF released a report on the California Physician Workforce in which the report stated that California still had sufficient (to more than enough) physicians overall. The report went on to state “the ratio of physicians to population growth in California over the past six years has risen from 177:100,000 population to 190:100,000 population in 2000.” This report caused quite a debate at the time as many people disputed its conclusions.

Well, now UCSF, along with the California Healthcare Foundation has prepared a revised report conceding that the physician supply re-count reveals that there are fewer physicians compared to the population and more specialized physicians than first thought. This new report came about after the CMA, disputing the 2001 report, sponsored legislation, AB 1586, which called for the Medical Board to administer a compulsory physician survey with relicensure. With this new source of information the principal author of the 2001 report, Dr. Kevin Grumbach, Director, Center for California Health Workforce Studies, and Chief of Family and Community Medicine at UCSF, went back to the drawing board and produced a second report that was released in late 2008.

New Information.

The MBC survey provided a source of new information about physician practices, including weekly hours of patient care, board certification, self-designated specialties, geographic practice area, and so forth. This new information was then compared to estimates of physician supply with the AMA MasterFile, and the Medical Board AMA physician counts were analyzed by specialty statewide and by county.

The new survey reports that 14 of the 58 California counties have an adequate supply of primary care physicians...12 counties have a supply less than half the recommended range.

The new survey reports that 14 of 58 counties have an adequate supply of primary care physicians

The new survey reports that 14 of 58 counties have an adequate supply of primary care physicians...12 counties have a supply less than half the recommended range.

On the other end of the spectrum Merced comes in as one of the lowest (35:100,000 primary care and 65:100,000 for specialists) as does Riverside with 34:100,000 primary care and 65:100,000 specialists.

While the second report acknowledges that the supply of physicians in California is substantially lower than previously estimated with barely an adequate supply of primary care physicians and an adequate supply of specialists, there is severe mal distribution across the counties.

The report summarizes that due to a shortage of primary care physicians and shrinking interest in going into primary care, California faces a growing threat to health care access.

Ω

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>PRIMARY CARE*</th>
<th>SPECIALISTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Mateo</td>
<td>66:100,000</td>
<td>147:100,000</td>
</tr>
<tr>
<td>San Francisco</td>
<td>100:100,000</td>
<td>270:100,000</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>53:100,000</td>
<td>123:100,000</td>
</tr>
</tbody>
</table>

*Family practice, general practice, general internists, general pediatricians, and geriatricians.
Dear President Obama:

On Main Street, the people of the United States have unreliable access to medical care. The poor access is particularly acute in adult primary care, and if current trends continue, will worsen rapidly. Alternate sites of care such as Emergency Rooms, subspecialty clinics, or Nurse Practitioner run clinics offer the American public less effective and efficient care than practices organized around physicians and the Medical Home concept. But you know all that. Your challenge is enormous. If you want every American to have access to routine preventative and efficient incident care, then you have some difficult decisions to make. You will need to make investments in primary care medicine while realigning incentives to streamline work in specialty care.

You will need to address the shortage of primary care physicians:

1. Make the patient load in primary care manageable. In most practices because of high demand for services and the need for large panels to provide a decent income, the work is overwhelming.
2. Attract physicians to this specialty by paying competitive salaries. Salary disparities are enormous and growing and the Medicare payment system is at the root of the fees charged and reimbursed by physicians.
3. Organize physicians into pre-paid multi-specialty groups so that information is freely managed and incentives lie with caring for patients collectively and not with doing more to generate income.
4. Increase the prestige of primary care by changing the name of the surgeon general to First Medical Officer and appoint someone with primary care credentials.
5. Develop training programs in medical schools and residencies that celebrate the Medical Home and Primary care Medicine.

The Permanente Medical Group (TPMG,) the largest multi-specialty group in the country, providing medical care to 3.3 million members is an integrated model of health care (Kaiser Permanente in northern California). I am one of the Physicians-in-Chief in the medical group. The TPMG Board and executive staff evaluate and reevaluate the care we provide so it meets the highest quality standards and the greatest satisfaction for patients. While we consider other ways to provide care, we have learned that primary care medicine is the key to provide both. Each member must have a personal physician, who is readily accessible to him/her and knows the member personally. The patient must be able to book a convenient appointment on line or by phone, and if specialty care is indicated that it be available in a timely fashion. And finally the experience in the office must be therapeutic and well-received.

Direct access to specialists for a limited number of conditions makes sense. Most patients, however, will benefit from seeing a primary care physician who will expertly manage their chronic conditions and provide for urgent needs. Adult primary care, pediatric care, and primary gynecologic care are the keys to providing high quality medical care. And if that is true, then a crisis looms. In the future, we will not provide that high quality care, because America does not have enough adult primary care physicians. The shortage becomes more acute in the years ahead, as medical students and doctors-in-training choose all other specialties, citing pay and workload issues. (Bodenheimer article in Annals 2007)

At TPMG, because of our multi-specialty model, we are very concerned about the supply of primary care doctors. The medical group has created a generous forgivable loan for new recruits and a retention program with financial incentives for current interns and family practitioners. TPMG pays consistently at or above market salaries. It is committed to reducing panel size and supporting the physician practice with chronic care managers and highly trained medical assistants and nurses. The physicians can schedule specialty consultations, lab and imaging studies with a simple order. So, in the short term, we have enough physicians and therefore are well-positioned to meet KP member needs. But what about the 2012 and beyond?

Mr. Obama, addressing the economic downturn and its effect on the citizens of the USA and the world requires that we solve health problems in all of our societies. (Jeffrey Sachs, The End of Poverty) Despite enormous expenditures,
life expectancy and ratings of health are much lower in the US despite per person outlays of multiples of other civilized countries. There are many political issues including whether employment based health care is what Americans choose, special interest considerations in a complex medical delivery system, and infrastructure issues which you are starting to address in the stimulus package. Medical research, education, and the role of public health all require attention, but the best models of care must be staffed with highly qualified primary care physicians. Your vision and charisma are needed to steer a medical system from the brink of chaos back to solid ground. Start now by planning to increase the number of doctors who choose primary care as their profession.

Sincerely,
Michelle Caughey, M.D.

For further reading on this subject, I recommend the following books and articles, just to name a few:


Three Kaiser Permanente physicians recently spent a couple hours with the students at the College of San Mateo bi-annual Health Fair. Left to right: David Murad, Dermatology; Dennis Nakamura, Physical Medicine & Rehabilitation; Darvin Smith, Infectious Diseases.
Society Needs to Start Understanding that Death is Inevitable

By David Goldschmid, M.D.

When we speak about a physician shortage, we must first define terms. In my view, the number of physicians per capita does not define a physician shortage. In fact that number is expected to rise and remain very high by world standards. In my view, there is a shortage when access to physicians becomes difficult. Thus, one must account for productivity as well as numbers of physicians when trying to define adequate supply. Productivity is measured by the amount of work done, or patients seen, and is related to hours worked and longevity of practice.

I will not attempt to discuss the issue of demand for services as it relates access and to the definition of a shortage. The aging of our population, the effect of boomers growing older, and the effect of possible universal coverage will work to make access more difficult.

**MEASURING PRODUCTIVITY**

There is little question that physician productivity is going down. First we can start at the end: retirement. The data is very suggestive that overall, physicians are retiring at an earlier age. There are no obvious or simple causes, but there are some trends that may help to explain this. Female physicians are more likely to retire from medicine earlier than male physicians (median retirement age: 61 vs. 65) and there are more female physicians now than before. “Furthermore, the impact of physician retirement will be bolstered further by the rapidly growing proportion of employee physicians, who have higher probabilities of retirement than self-employed physicians in either solo or group practices.”

Finally, many have elected to retire rather than struggle with overregulation, falling reimbursement, and a hostile legal environment.

**CHANGING EXPECTATIONS**

Next, there is the issue of the expectations of new graduates. Local large and very large groups report that it now takes 2-3 physicians to fill one FTE. This is because many have very specific work hour requirements due to increased family commitments. Physicians moving into the area are having families earlier than before and are usually married to a spouse who must also work (often another physician). Residency directors will explain that there is a greater reluctance to work long hours, weekends, see hospital patients, or be on call than in the past. Small groups and solo practitioners report they can no longer recruit.

**THERE ARE MARKET FORCES.**

Physicians are the only professionals who have experienced a real drop in income over the past few years. They simply cannot sustain a high level of living in areas where expenses are high.

Medicine has become a “go to” profession. Unlike the past, people now frequently go to Medical school with the expectation that they will never practice but use the degree to “go to” another place such as consulting for IT companies, working for pharmaceutical companies, working at venture capital companies, etc. Lawyers have always done this (often becoming politicians) but this is a new trend in medicine. Here is a quote from a Wall Street Journal blog on “Why More Med Students Won’t Mean More Doctors.” “A salary of 150K per annum for someone with 12 yrs education/training after high school, 200K of debt, expected to work 60-70 hr weeks, consistently second guessed by Insurance companies and panned in the public as greedy and overpaid, with a feeling that the future income trajectory is down, just will not make attract the brightest amongst our youth.” Once medical students figure all this out, they leave the profession before they start.

International medical graduates have come to this country to train and practice and have traditionally filled the void left when there are no US grads who will do the job. Now, they are coming to train, but are going back to their own countries where they can now often do better than if they stay here. The days of the Canadian and European physician immigration to the
Understanding that Death is Inevitable

universal truth: medical costs sustained the number of practicing physicians.

US are over. With the average Primary Care Physician in London (GPs) making upwards of $200,000-$250,000 US per year it is not difficult to understand. When they do stay, however, they tend to be very productive.

Medical tourism is a new global force.

Americans who pay cash for their care go abroad to get cheaper care. This will serve to reduce access here in the long term. At the same time, we have what I call reverse medical tourism where people from other countries who cannot afford to pay cash for care in their own countries come here to get it for free thanks to EMTALA. This will stress our system and access even more.

Society has effectively shut off the supply of Primary Care Physicians by refusing to pay for cognitive care. Less than 2% of medical students plan a career in primary care. We have always been willing to pay for procedures, but have decided that now all we really value are very exotic procedures and technologies. Thus we have started to shut off the supply of General Surgeons by not paying them as well. The virtual elimination of these two specialties will cripple access to care.

Cost relative to physician supply.

All governments have discovered one universal truth: medical costs sustained by any society is directly related to the number of practicing physicians. The more physicians a society has, the greater the medical costs. The fewer physicians a society has, the lower the costs. Very few parameters, which have been related to medical costs, are as consistent as this one. Governments across the world have struggled to balance their responsibility to provide access to care for their sick citizens against their responsibility to protect their peoples’ economy.

A Complicated Convergence of Forces

I believe that what we are witnessing here are multiple forces, working independently, determined to reduce costs by eliminating our desire to practice while at the same time professing to care about access, but knowing reducing access must happen. The hostile governmental environment and over-regulation physicians have experienced are designed to make reimbursement difficult and low, and to make medical practice undesirable. These forces result in reducing the number of practicing physicians or at least their productivity, to reduce access to reduce costs. Over-regulation, bad press against physicians, lowering reimbursement, proliferating HMO principles where profit is tied to reduced productivity, trying to punish us for virtually anything that can go wrong, artificial constraints on marketplace forces such as constraints on balance billing, and Orwellian systems set up to pay us for doing our jobs well instead of simple systems, are not accidents. The intent is to reduce access and it is working. There are lots of people responsible for policy. This is not a conspiracy by a single powerful source. These actions are taken by different people who have come to the same conclusions and are operating independently, but their policies all have a similar desired effect. We are beginning to experience a physician shortage that policy makers hope will reduce costs. Until someone somewhere discovers a better way to reduce the overwhelming burden to society that medical costs will soon become, the physician shortage-defined as access to physicians-will continue and be allowed to get worse. Although physician numbers may continue to rise over the next few years, access to physicians will be reduced.

When society finally understands that death is inevitable and that lawyers cannot manage medical care, we will be able to devise rational cost containment. Then government will act to make the physician shortage improve. Ω

1. Trends in physician retirement.
Center for Health Policy Research, American Medical Association, Chicago, IL 60610, USA.
Hardly a week goes by without another news article or medical journal editorial being published on the medical crisis at hand regarding our need for more primary care physicians (PCPs), and the lack of medical students heading in that direction after graduation. This has been a discussion I’ve had with groups of colleagues who look back at our medical school graduations in the late 1980s and early 1990s—not all that long ago—when we were vying for top places at UCSF, University of Chicago, Columbia, the Brigham—in what?—primary care residencies. Sure there were the surgeons, and those going on to research, but for the majority of us, the question wasn’t if we were entering a primary care residency, it was simply which one.

Sadly, those days have gone. There are many learned folks working on what is needed to try and alter the trajectory of the new physicians just entering practice and how to recruit medical students who will follow in our footsteps in order to avert the national shortage of PCP’s that looms on the horizon, I’m not going to focus on that today. Instead, I would like to increase awareness about my biggest concern as we watch the decrease in the PCP pipeline and that is the patient population that will be hit hard and in the immediate future. Who is going to step up to serve our neediest patients as the few primary care physicians who are doing so now, grow older and ultimately retire?

As you may be aware, the Health Plan of San Mateo (HPSM) is the managed care entity that serves the majority of the lower income, underserved patients in San Mateo County. It does this via Medi-Cal, Medicare and other programs. While 55% of its members are children, the remainder is made up of seniors, the disabled, and indigent adults living in our community.

The provider network serving these patients is a varied group of dedicated physicians. One third of the patients have their primary care provided by the physicians and clinics of San Mateo Medical Center. These services are especially critical in the South County area because there are few private PCPs open to accepting new HPSM members there. Ravenswood Family Health Center in East Palo Alto and its associated clinic, Belle Haven, are key safety net clinics in the South County for adults, as are the Lucile Packard clinics for the pediatric set. Ongoing support for these institutions, and their ability to keep attracting new clinicians, will certainly be critical if primary care for the underserved is to continue in this county. The same holds true for Coastside Family Health Center, a critical source of health care for families living in the coastal peninsula.

Recently we have begun to get assistance from our colleagues at the Palo Alto Medical Foundation and Kaiser Permanente in Redwood City. The willingness of these sites to accept some HPSM members has allowed us to expand access in our South County area and has improved prospects for the future.

However, in pockets of the South County and Mid-County, and particularly in the North County, there are committed primary care physicians in solo and small group practices who are a key portion of the lifeblood of HPSM’s provider network. These internists, family practitioners, pediatricians and general practitioners have opened their practice doors and their hearts to HPSM members. If you look on the HPSM website (www.hpsm.org) or in any HPSM Provider Directory, you’ll see their names—physicians who, along with our clinic partners, make the difference between a patient having to wait two months to be seen and two days. They have allowed our access for routine care to meet and exceed state standards because they serve over 82% of HPSM members in the North County area. They go the extra mile for our members, and will squeeze in an extra patient when I call. These unsung heroes make I believe it is time that we look carefully at how to assist primary care physicians in private practice in our county with succession planning.
HPSM viable because “insurance” is worthless if there is no one who accepts it.

It is these physicians that I worry about. Physicians who, when I ask, “What is your succession plan,” laugh and say—“I am my succession plan.” Then they tell me of their struggles to get anyone to join their practice, how expensive the county is to live in, to practice in, etc. etc. And each year I see them getting older, just as I am. And I hear about fewer and fewer people interested in joining small practices, or visiting patients in nursing homes, like these doctors do, and I worry.

I know this is not just a Health Plan concern; it is also a county concern, a Medical Association concern and a national concern. If these physicians ultimately retire and have no one to take their place, it is not just HPSM members who lose their physicians, but eventually private pay patients as well. My concern is not only that HPSM patients will be impacted first, but also that they will have a lot fewer alternatives for care than others will. And then the scenario of “insurance” without access, which is already a reality for some of our indigent adults, will become the norm for our Medi-Cal children and Medicare seniors and the disabled. That is something we cannot afford to let happen.

I believe it is time to actively assist private practice primary care physicians in our county with succession planning. Housing has been a key barrier to attracting partners, perhaps the current economic difficulties and down-turn in the real estate market with its housing foreclosures will ultimately work in our favor by adjusting housing downward, thereby removing a recruitment deterrent. Since succession planning needs to happen before the current PCP pool is lost to death and retirement, we need to begin working now. Perhaps a combined effort from the Medical Association and other interested bodies such as the Hospital Consortium, the County Board of Supervisors and the local medical schools could provide strategies to employ before the need overwhelms us. We should consider this a call to action, because time is of the essence. It won’t only be our poorest, most vulnerable patients that suffer if we let time run out. Their circumstance will merely foreshadow our own fate.Ω


Letters to the Editor

February 13, 2009
Dear Dr. Sheppard:

In response to the Nov/Dec issue of the Bulletin, I am writing to inform you of another worthwhile volunteer opportunity.

Vision Health International brings vision care, from surgery for Ptosis, Strabismus and Cataracts to providing eye exams and glasses to patients in medically underserved countries, primarily in Latin America.

Importantly, VHI evolved from work begun in Ecuador by Dr. Rodney Abernethy, one of our community’s own Ophthalmologists. I began volunteering with him in 1983 and continued until retiring in 1998.

Working with a team of nurses, physicians, administrators and others, all working together, was joyous and habit forming. I loved the teamwork, dedication, the camaraderie, the minimal paperwork, the expressed gratitude of the patients and the welcoming of their communities.

VHI needs volunteer Ophthalmologists and Anesthesiologists. I would be happy to talk to interested physicians about VHI. It is a 501(c)(3) Nonprofit Tax Exempt Corporation. Their office address is 1915 Main Street, Napa, CA 94559

Sincerely,
Stephen H. Rovno, M.D.
939 Harvard Road
San Mateo, CA 94402
(650) 342-4718

We welcome articles, opinion pieces and letters for publication on any subject related to the practice of medicine. Let us hear from you!

LOOKING FOR CME?

Our home page has the current month’s list including short and multi-day courses in the Bay area and nearby communities.
Go to: www.smcma.org
new primary care physicians include Kaiser Permanente and the Palo Alto Medical Foundation (PAMF). They have multi-specialty group practice models where primary care physician salaries are subsidized by the income generated by specialists. These groups are able to offer the salary and work-life balance that recently graduated primary care physicians are seeking; thus they have become the choice for recent primary care residency graduates who want to practice in this area. Patients still appear to desire options other than Kaiser or PAMF; however, for those options to still exist and flourish, greater emphasis must be placed on the value of primary care.

**Primary Care and the World Model**

Research indicates that areas with more primary care physicians have better preventive care and overall health outcomes for patients. In a 2005 study, researchers from the Johns Hopkins School of Public Health analyzed data from 3,000 counties nationwide and found that a higher ratio of primary care physicians to specialists in a population results in lower mortality rates and lower cost. In 2006, the Dartmouth Atlas Project found that states relying more on primary care rather than specialty care for the treatment of patients suffering from chronic illnesses had lower health care spending and better quality outcomes. As a whole, the United States spends more money on health care than any other nation and gets fewer results, according to studies done by the World Health Organization and the independent Commonwealth Fund.

“If you look at how Spain, Denmark, France or New Zealand have transformed themselves in terms of delivering care, they have done so on a foundation of robust prevention and comprehensive integrated primary care as the very basis on which their health care delivery systems are built,” said Paul Grundy M.D., MPH, chair of the Patient-Centered Primary Care Collaborative, a coalition of national business leaders, policymakers, insurance companies and physician groups that advocates for establishing primary care as the foundation of the U.S. health care system. “Without a foundation of robust prevention and primary care, you cannot get to the other things you need in any meaningful way.”

To follow a similar model in the U.S. would require a fundamental shift in reimbursement to better reward the efforts of primary care physicians to keep their patients healthy, thus reducing emergency room costs and the cost of managing chronic illnesses in future years. The health care plan touted during President Obama’s 2008 campaign included a number of elements that would benefit primary care physicians, including recognition that fair compensation is an essential element of health care reform. His plan would also increase reimbursement rates and expand training-grant and loan-repayment options for physicians who enter the primary care field, increase reimbursement for preventive care and support the development of revenue models that provide incentives for care-management programs, team care and medical home strategies.

**New Initiatives**

“Medical homes,” a new model of primary care where teams of physicians, nurse practitioners, physician assistants and others provide comprehensive primary care services that also focus on management of patients with chronic illnesses, is also supported by the American College of Physicians and the California Academy of Family Physicians. According to these groups, this model promotes more access through expanded hours and use of telephone, e-mail and electronic medical records. The inclusion of $19 billion in grants and incentives for companies and physician practices to purchase health information technology in the recently signed federal economic stimulus package is a step toward assisting physicians to implement electronic health records, one of the keys to this concept.

More than 30 states and some of the nation’s largest payers, including United Healthcare, Aetna and Blue Cross, have already initiated Patient-Centered Medical Home (PCMH) pilot projects. SCHIP and Medicaid programs have also played key roles as vehicles to implement PCMH projects at the state level. Initial results appear promising and deserve further investment of resources. Ultimately, the groups that realign financial incentives with health care delivery goals will result in more coordinated, integrated and ongoing care that should increase quality, reduce costs, enhance access and improve both patient and physician satisfaction.

The other residual benefit of “medical homes” and other primary care reform proposals would be increased interest among medical students in pursuing a career in primary care. Additional incentives could include financial support for medical schools that place an emphasis on primary care and increase enrollments, as well as waiving tuition and fees for students who choose a career in primary care or, at least, for those who agree to work in community health centers in underserved areas or treat underserved patients for a minimum of two years after graduation.

With the federal economic stimulus package now signed, attention will turn toward health care reform as another key element of jumpstarting the economy. If President Obama’s campaign tenets hold true, then progress in addressing the primary care shortage can be made. Without necessary changes, other health care reform initiatives cannot, and will not, succeed.
My good friend, Dr. Walter Gaines

I met Walter in 1961. He practiced radiology down the street from my new office in San Mateo. I referred many of my patients to Walter’s office for radiology studies. I was very impressed with his clinical approach to radiology. At lunch one day he told me that he had done general practice in Chicago before coming to California and taking a radiology residency and starting his radiology practice here.

For many years Walter, often with his wife Beverly, became involved in volunteer work in helping people in Africa, the former Soviet Union, and Cuba. This work included setting up a clinical laboratory in Africa, and providing medications for needy people in the former Soviet Union and Cuba.

During the time he was actively practicing radiology in San Mateo he volunteered at UCSF in the Department of Radiology, teaching radiology residents the art and science of clinical radiology. He soon became Clinical Professor of Radiology.

In 1988 a request came from Samaritan House to the San Mateo County Medical Association to explore developing a free medical clinic for persons in our community who did not have health insurance nor the means for receiving medical care. Walter and a group of us initiated plans to start a free clinic at the Samaritan House. Walter worked with Norcal Mutual to provide our volunteer doctors with medical liability insurance.

Walter also completed the 50 page questionnaire required to acquire state licensing. He later worked for 2 days with the state medical licensing person who inspected our one room clinic; we received the license. Walter had an excellent mind and the ability to handle details with patience and accuracy.

During his very active life, he had three children and subsequently grandchildren all of whom have been close to him. His family was always loving and devoted to him. Walter and Beverly were serious travelers; going to the four corners of the world and studying the various peoples and cultures.

Dr. Walter Gaines created a legacy which will continue through his past excellence in practicing radiology, teaching residents, ongoing fruits of his volunteer work, and raising a fine family. He, indeed, made the world a better place because he was here.

William L. Schwartz, MD
Membership Update

NEW MEMBERS
ROBERT KIM (EM)
S. San Francisco

FALGUNI PATEL (PSY, CHPSY)
San Bruno

MILAN PATEL (RO)
S. San Francisco

TINA TAN (OBG)
Daly City

ROBERT TSENG (NEP, IM)
Daly City

RETired
ALLAN MARKS, M.D.

DECEASEd
ROBERT BLAHUT, M.D.
CHARLES LOBEL, M.D.
**Classifieds**

**PHYSICIANS MEDICAL CENTER IN DALY CITY**
Premium Modern Medical Space available at 901 Campus Drive. Building has on-site pharmacy, imaging center, & surgery center. Spaces available for sublease & lease of 515 sf, 1,129 sf and 2,02 sf (spaces have no building “load” for common areas) Contact: Trask Leonard, Bayside Realty Partners, 650-949-0700, tleonard@baysiderp.com

**SAN MATEO MEDICAL BUILDING**

**BURLINGAME MEDICAL BUILDING**
Location on El Camino Real, Burlingame; across the street from Mills-Peninsula Hospital; approximately 960+ square feet for lease; includes waiting room, reception/administrative area, 1 office and 4 exam rooms. Bathroom in suite. Call Alipate Sanft, SC Properties, 650-342-3030 x212.

**525 VETERANS BLVD**
Spaces from 1,045 – 2,579 rentable square feet available on ground floor with high visibility on Veterans Blvd, located close to downtown Redwood City and immediately off Whipple Ave/101 with high parking ratio. Trask Leonard, Bayside Realty Partners, (650) 949-0700.

**LAUREL MEDICAL CENTER**
Medical suites available from roughly 800-1,000 sf available that offer multiple exam rooms, reception area, restrooms, and offices. Located at high profile intersection of Brittan & Laurel Avenues in downtown San Carlos with excellent on-site parking. Trask Leonard, Bayside Realty Partners, (650) 949-0700.

**OFFICE TO SHARE, BURLINGAME**
Solo practitioner office with space available due to Concierge internal medicine practice. Suitable for primary or satellite office. Turnkey or space rental. Contact: Robert H. Kubin, M.D., 1828 El Camino Real #704A, Burlingame, Ca 94010. Phone: 697-5920. email: bob@drskubin.com

**REDWOOD CITY OFFICE SPACE: TUESDAYS & FRIDAYS**
New office space available for part time use in Redwood City. 2200 sq ft, large waiting room, 3 exam rooms, consultation room. Suitable for satellite office. Available Tuesdays and Fridays. Brian Lipson, MD. 650-216-6111 email:Brianlipsonmd@sbcglobal.net

**SAN MATEO OFFICE SPACE FOR SUBLEASE (MEDICAL ONLY)**
101 S. San Mateo Drive, 3rd Floor, 1,234 Useable Square Feet, 4 Exam Rooms, Office, Nurses’ Station, Large Waiting Room, Available Immediately on MON - WED - FRI., For details, please call (650) 906-4998 or send email to: larrymjanes@yahoo.com

**ATHERTON SQUARE MEDICAL/DENTAL BUILDING**
A newly upgraded Class A building offers a variety of spaces from 1,166 sf and up for medical/dental use at 3301-3351 El Camino Real, Atherton. Tenant improvement allowances available to design suite to meet your needs. Excellent on-site parking, close to Stanford and Sequoia. Trask Leonard, Bayside Realty Partners, 650-282-4620 or Alice Teng, Colliers, 408-282-3808.

**PHYSICIAN’S BILLING SERVICE, INC**
Complete accounts receivable management. Service customized for the individual physician. Serving physicians for over 30 years. For more info: www.pbsvc.com Richard Allen (760) 625-6399

**WANT TO PLACE A CLASSIFIED AD?**
Only $40 for members and $45 for non-members! Call (650) 312-1663 for more information.

---

**2009 DIRECTORIES ARRIVING MARCH 5TH. ORDER YOUR EXTRAS TODAY**

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ZIP CODE</th>
<th>PHONE</th>
<th>FAX</th>
<th>E-MAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRICE</th>
<th>QUANTITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Members $50 each
Non-Members $65 each
TOTAL

Mail to: SMCMA
777 Mariners Island Blvd., Suite 100
San Mateo, CA 94404

Make checks payable to
SAN MATEO COUNTY MEDICAL ASSOCIATION
What’s the Big Deal with NORCAL’s CME?

Last year NORCAL processed 15,264 Continuing Medical Education registrations — more than the number of our policyholders! Why? Because NORCAL policyholders use our unparalleled CME program over and over again. Visit www.norcalmutual.com today, or call 800.652.1051. NORCAL. Your commitment deserves nothing less.

NORCAL is proud to be endorsed by the San Mateo County Medical Association as the preferred professional liability insurer for its members.

You practice with passion. Our passion protects your practice.