Dean's Newsletter
July 6, 2009

Table of Contents

Another Cycle Begins – But This One Has National Significance

July 1st marks the beginning of another cycle in the life of academic medical centers. Newly minted MDs, most having graduated from medical school in the last month, begin their official responsibilities as Residents in hospitals across the nation on July 1st – generally after a week or more of "orientation." In addition, graduates of residency programs begin clinical fellowship programs in medical, surgical and hospital based specialties and subspecialties. In particular I would like to welcome our new Residents and Fellows to Stanford and wish them the best of future success. They are entering training in graduate or post-graduate medical education at a time of great excitement and opportunity – as well as turmoil and uncertainty – in American medicine. And, for the first time in many years, academic leaders, physician colleagues and politicians are questioning the choices Residents and Fellows have made in pursuing careers in primary care vs subspecialty medicine. In fact concerns about the national shortage of primary care physicians (now less than 50% of the US doctor workforce) have become front and center in the healthcare reform debate.

As I noted in my March 30th Dean's Newsletter the majority of 2009 graduating Stanford students, like others around the country, chose specialty track residency programs. In fact, on a national basis, the most "competitive" and sought after residencies include dermatology, neurological surgery, orthopaedic surgery, and otolaryngology – as well as anesthesia, radiology, and emergency medicine. Fewer students select "primary care" areas (which generally include family medicine, internal medicine, pediatrics and in some areas, obstetrics-gynecology). This has led many to opine on the reasons for these choices, which include factors like the level of medical student debt, projected income differentials between careers in primary care versus specialty care (which over the course of a 35-40 year career can amount to as much as $3.5 million), the social, geographic background and gender of the graduates as well as "life-style choices," and the perceived value of "primary care" at teaching hospitals and in the community (where it is often considered a "lost leader"). These and other factors converge to influence choice – which has largely moved away from primary care over the last decades in the US.

A recent report from the Robert Graham Center, with support from the Josiah Macy Jr. Foundation, entitled *Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student and Resident Choices?* (see: http://tinyurl.com/cq28nv) affirmed these factors and offered recommendations to address this challenge that included:

- *"Create more opportunities for students and young physicians to trade debt for service, through effective programs such as the National Health Service Corps.*
- *Reduce or resolve disparities in physician income*
- *Admit a greater proportion of students to medical school who are more likely to choose primary care, rural practice, and the care of the underserved.*
- *Study the degree to which educational debt prevents middle class and poor students from applying to medical school and potential policies to reduce such barriers.*
- *Shift substantially more training of medical students and residents to community, rural and underserved settings.*
- *Support primary care departments and residency programs and their roles in teaching and mentoring trainees.*
- *Reauthorize and revitalize funding through Title VII, Section 747 of the Public Health Service Act*
- *Study how to make rural areas more likely practice options, especially for women physicians.*
- *New medical schools should be public with preference for rural communities."*

A number of these recommendations are sensible and I personally agree with many but not all. I should also add that while I strongly support the importance of a better balance in the physician workforce in the US, I also believe that Stanford's role remains unique and should stay focused on training and educating future leaders and physician-scientists and scholars. There is also a dearth of these individuals, and we have the resources and expertise to train the academic and research workforce of tomorrow – which is also critically important to the future of healthcare reform.

Back to primary care: two brief and informative articles in the June 25th issue of the New England Journal of Medicine – *A Life Line for Primary Care* and *Easing the Shortage in Adult Primary Care –Is It All about Money?* – offer additional data and perspective to this topic and are worth reading. It is notable that on July 1st, the very day that new Residents officially began their new training, the Centers for Medicare and Medicaid Services (CMS) announced proposed changes to policy and payment rates that begin to address some of the compensation issues mentioned above (see: http://tinyurl.com/kqsdym). These policy recommendations, while certain to engender considerable discussion, go to the heart of the matter by recommending a payment structure that will increase payments to internists, family physicians, general practitioners and geriatric specialists by 6-8% in 2010. Given the imperative to reduce the overall costs of health care, these proposed policies reduce payments to certain specialists (e.g., compensation to cardiologists would fall by 11% and radiologists would have reductions

in payments for imaging procedures using equipment like CT and MR scans approaching 20%).

How these policies will be actualized remains to be seen, but the directions being taken are not surprising and are quite consistent with what I have heard at numerous recent meetings and discussions in Washington. Some of these ideas were also reflected in my observations in an earlier issue of the DNL and in a podcast I did with Paul Costello, Director of Communications and Public Affairs (http://med.stanford.edu/121/2009/pizzo.html). As these and related changes unfold, it is likely that we will experience impacts at multiple levels and dimensions.

In tandem with the possibility of increasing payments for primary care physicians (and concomitant reductions in compensation for selected specialists and technologies), considerable discussion has taken place recently about the physician workforce *per se* as well as graduate medical education (GME) slots and the payment for GME through Medicare. While a number of groups, including the Association for American Medical Colleges (AAMC) have advocated for significant increases in medical school class size – up to 30% – to meet projected shortages of physicians, I believe (and have previously stated) that this needs be more carefully assessed. Increasing the number of medical school graduates, without also placing limits on career choice or even practice location, will likely only sustain our current system and its consequences.

Of course I am well aware that restricting or limiting choice has been anathema to our current educational paradigm, and I would quickly add that shifts in that paradigm are needed. Indeed, while there may be a need for more physicians in selected areas, it seems much more sensible to look at the healthcare workforce more broadly and to redefine the practice of primary care. This would require the addition of other health professionals – nurses and advanced nurse practitioners/physician assistants – who could and should assume some of the tasks previously done by physicians. Creating new teams of care providers that create complementarity and synergy in the management of patients with acute and chronic disorders is more sensible than simply increasing the number of doctors. At the same time, defining the workforce and its responsibilities in the absence of knowing what healthcare will look like in the decade ahead poses significant challenges. That said, these processes will almost certainly need to progress in parallel.

In addition to compensation, debt relief and related workforce issues, the length of education and training of physicians will need to be examined. In doing so, there should be no rush to a "one size fits all" mentality, since the knowledge and skills vary considerably depending on the nature of the medical career being pursued. However, approaching medical education with an eye toward improving efficiency and effectiveness is an imperative – a process which has begun in certain specialties (e.g., cardiac surgery) but which needs much more effort. Importantly, these considerations also underscore the importance of addressing the continuum of medical education – which begins post-high school and extends through residency and fellowship – in a much more interrelated fashion. From the time a student enters college to the point of entering the workplace there is a range of 12-21 years depending on the education pathways

chosen. While there is again discussion about reducing the length of medical school from four to three years, equally if not more important considerations should focus on college preparation as well as graduate and postgraduate training. And, as mentioned, these need to be adjusted to the missions and goals of the medical school, university, career path and other important factors that will determine the future of medicine and science.

Change poses challenges, but I always welcome the prospect of using change to improve our missions and goals. The aspects of the healthcare debate that extend to education and training compel us to examine what we can do to improve the effectiveness and efficiency of our programs across the continuum. The silver lining is that this will permit us to strive to improve and integrate our programs so that Stanford remains a leader in education and training.

Whether (and Weather) National Healthcare Reform

My 23 years in Bethesda at the NIH offered numerous glimpses of the Washington scene. Summers were always hot and humid with intense thunderstorms nearly every afternoon. Indeed the air was usually even more hot and humid after the storm had ended. In some ways the weather of a Washington summer is a metaphor for the intensity of the climate surrounding healthcare reform. To say that the debate is heating up is a gross understatement. This is not surprising, given the magnitude of the economic challenges – unsustainable in their own right – and the number of constituencies (including doctors, hospitals, pharmaceutical companies, and the insurance industry just to name a few) that are also unsustainable in their current focus and formulation. During the past months I have made a significant number of trips to DC to attend meetings at the White House or policy meetings with professional organizations (e.g., Association for Academic Health Centers, Association of American Medical Colleges) who share concerns about healthcare in the US and the prospects for its reform.

Virtually everyone believes that if change comes it will happen before the end of the calendar year and that the peak of the pressure points will take place in the fall when the Congress returns from its summer recess. The stakes are enormous and the convergence (or divergence) of the Executive Branch and the Legislative Branch will speak volumes about our future. It is also important to underscore that, given the political forces that will surge during the 2010 election year, if change fails to take place this year the prospects for serious reform in health care will be squandered for the immediate future. In reality, however, the situation will only grow worse, since failure to seriously curtail ever-rising healthcare expenditures in the US will only become more challenging in the years ahead as the percentage of the GDP devoted to healthcare continues to rise to unsustainable (and unjustifiable) levels.

The other thing that virtually every constituency group seems to believe, at some level, is that their own interests will not be affected – that they have somehow struck a deal with the Congress, the White House or each other. I realize that my own views are likely less informed, but from what I can see it is unlikely that any perceived deal or conclusion is sacrosanct at this point. In fact, the only thing that seems to have broad

concurrence is that cost containment is critical (although there is debate about whether this would mean achieving true reductions or changing the rate or slope of the increases).

I won't reiterate the various issues, factors and forces shaping the health care debate since I covered those in a past DNL and podcast (http://med.stanford.edu/121/2009/pizzo.html). But I would recommend a couple of articles that will amplify the points of debate. One is Dr. Atul Gawande's now famous piece entitled *The Cost Conundrum* that appeared in the June 1st issue of the ***New Yorker*** (see: http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande). Gawande explores the reasons why healthcare expenditures are highest in the nation in the town of McAllen Texas and, in his insightful writing style, points out that the costs of care are not associated with improved outcomes. In fact, as has been reported over the years from the Dartmouth group, an inverse correlation between Medicare expenditures and outcomes has been observed in a number of regions of the US.

The Dartmouth Atlas Project (see: http://healthcarereform.nejm.org/?page_id=597) displays Medicare reimbursements per enrollee by hospital referral region or by state. If you review the interactive map (also made available by the NEJM) the differences in Medicare reimbursements are quite striking. In places like McAllan Texas, where they rose dramatically during a fourteen-year period (1992-2006), they can reflect physician practice and use of technology and procedures in a remarkable fashion – which is not necessarily associated with better outcomes. Understanding these associations is important and, while a number of caveats can be offered, it cannot be denied that costs around the country (or even in geographically proximate areas) vary widely and are almost certainly influenced by physician practice. Indeed, while the overall percentage of health care dollars attributable to doctors is only around 10% (although it must be noted US physicians are among the highest paid in the world) the reality is that physicians account for the determination of a very high proportion of health costs. These issues are now among the centerpieces of the healthcare debate.

As I noted above, whether there is significant healthcare reform in 2009 depends on many factors. A bell-weather at this juncture is the burgeoning debate over a public alternative to private insurance. There are many points of view about this, including the assertion that private insurance should not be negatively impacted since it is critical to controlling choice, access and costs. To me this is a bogus argument since the market-driven health insurance industry has played a significant role in generating the problems we now experience. This issue is well reviewed by Dr. Arnold Relman (former Editor of the New England Journal of Medicine) in the July 2nd New York Review of Books in an article entitled *The Health Reform We Need & Are Not Getting* (see: http://www.nybooks.com/articles/22798). While this review will engender various reactions, it further underscores the point that the argument that the market place is the best way to reform healthcare simply doesn't ring true. Certainly the last four decades in the US speak to that – as do the seminal studies of Kenneth Arrow (for which he won the Nobel Prize) that showed that healthcare is not a commodity to which general economic principles can be applied.

In the end, the thunder and lighting in Washington this summer and fall will determine whether we see progress in healthcare reform. I still believe that in the long run we will be best served by a single payer system coupled with private options, not too dissimilar from that in the UK. In the interim, reform that includes a public option to private insurance, controls costs for drugs and technology, rebalances the healthcare workforce between primary and specialty care as well as creating teams of physician and other professional providers, and creates a focus on quality and safety and an orientation toward health as well as disease management would be among the necessary components. In tandem with this is the hope that healthcare reform will permit doctors to reclaim their place as professionals who serve the welfare of patients and communities and not just as members of the industrial medical complex that is now so dysfunctional and unsustainable.

Dr. Keith Humphreys Takes Leave to Serve in Washington

Dr. Keith Humphreys, Professor of Psychiatry and Behavioral Sciences, will be taking a leave of absence to serve as the Senior Policy Advisor, White House Office of National Drug Control Policy. Please join me in congratulating Dr. Humphreys and wishing him success in his new role – and of course, anticipating his return to Stanford in the not too distant future.

Awards and Honors

- ***Dr Sherry Wren***, Professor of Surgery, has been selected as the Loyola University Chicago Stritch School of Medicine Alum of the Year for her contributions to medical education. This is a great and well-deserved honor. She will receive her award in September in Chicago.
- ***Richard Gaster, fourth year MD/PhD student, and Drew Hall, a fourth year student in Electrical Engineering***, won the inaugural Institute of Electrical and Electronics Engineers first prize in the "Change the World Competition." The Stanford team also won first prize in the National Collegiate Inventors and Innovators Alliance Biomedical Engineering Idea competition for inventing the "lab-on-a-stick." Congratulations to Richard and Drew.
- ***Jacqueline Baras Shreibati*** , Medical student and Health Service Research Masters Graduate, has just won the Student Poster Award at the Academy Health annual meeting in Chicago, and was also selected as one of the four best abstracts submitted by students to be featured in a special panel of top student projects. Contratulations, Jacqueline.

Appointments and Promotions

R. Kim Butts-Pauly, has been promoted to Professor (Research) of Radiology, effective 7/01/09.

Mary Ann Carmack has been promoted to Adjunct Clinical Assistant Professor of Pediatrics effective 7/01/09

Dwight Chen has been promoted to Adjunct Clinical Assistant Professor of Obstetrics and Gynecology effective 9/01/09

Stevens Y. Kim has been promoted to Adjunct Clinical Assistant Professor of Ophthalmology effective 4/01/09

Amy Oro has been promoted to Adjunct Clinical Assistant Professor of Pediatrics effective 5/01/09

Gary Peltz has been appointed to Professor of Anesthesia, effective 7/01/09.

Thomas Plante has been promoted to Adjunct Clinical Professor of Psychiatry and Behavioral Sciences effective 9/01/09

Peter Schubart has been promoted to Adjunct Clinical Associate Professor of Surgery effective 5/01/09

.