Medical schools don’t teach these key lessons – and it’s ruining our health

Many Americans are getting more health care than they need.

By G. Richard Olds  December 31, 2014
G. Richard Olds is vice chancellor of health affairs and the founding dean of the UC Riverside School of Medicine.

The United States spends more money on health care than any other country in the world. So how does Costa Rica outperform the United States in every measure of health of its population? Costa Rica is healthier because its government spends more money than ours does on prevention and wellness.

In our country, we have left vast segments of the population without affordable care and we do not focus on wellness or chronic disease management. We don’t consistently control the glucose levels in diabetics and, consequently, too many go blind or lose a limb. Too often, hypertension goes untreated until the patient has a stroke or kidney disease. Then, all too often, these individuals go on medical disability with far more societal expense than the cost of the original health management.
Sadly, it has become the American way to leave many chronic diseases untreated until they become emergency situations at exorbitant cost to the U.S. health-care system. For many patients, this care is too late to prevent life-changing disabilities and an early death.

When people ask me why we started the UC Riverside School of Medicine last year – the first new public medical school on the West Coast in more than four decades – I talk about the need for well-trained doctors here in inland Southern California. But we also wanted to demonstrate that a health-care system that rewards keeping people healthy is better than one that rewards not treating people until they become terribly ill. As we build this school, we have a focus on wellness, prevention, chronic disease management, and finding ways to deliver health care in the most cost-effective setting, which is what American health care needs.

We also teach a team approach to medicine — another necessary direction for our health-care system. If you have a relatively minor problem, your doctor might refer you to a nurse practitioner or physician assistant for follow-up. This kind of team care makes financial and clinical sense, particularly since we have such a national shortage of primary care doctors. The good news: Even among physicians, the team approach, or medical home model, is gaining ground, with the Affordable Care Act accelerating change.

For all the talk about the lack of health insurance in this country, we don’t often discuss the other side of the problem – the fact that many Americans get more care than they need. You may have heard advertisements that you should have your wife or mother get a total body scan for Mother’s Day, because it will find cancer or heart disease. There is no evidence that this screening is a good idea. But in the U.S., we often encourage people to do things that have no proven benefit, and our churches or community centers sponsor these activities.
For all these reasons, we must shift the focus of health care to prevention. Two of the most profitable prescription drugs in the U.S., according to some sources, are those that reduce blood cholesterol and prevent blood clots — both symptoms of coronary heart disease, a largely preventable condition. Shouldn’t we be spending at least as much on prevention as we do on prescriptions? Closely connected to prevention is wellness. So many of our health problems in the United States are self-inflicted, because we smoke, eat too much, and don’t exercise. Doctors need to “prescribe” effective smoking cessation programs, proper diets and exercise as an integral part of care.

One way to accomplish this shift is to teach it to future doctors. At UC Riverside, we are supplementing the traditional medical school curriculum with training in the delivery of preventive care and in outpatient settings. Our approach is three-pronged. First, we work with local schools and students to increase access to medical school through programs that stimulate an interest in medicine and help disadvantaged students become competitive applicants for admission to medical school or other professional health education programs. These activities start with students at even younger than middle school age, because that is when students begin to formulate ideas about what they want to be when they grow up. We focus on students from Inland Southern California because students who live here now will be among those best equipped to provide medical care to our increasingly diverse patient population. Doctors who share their patients’ cultural and economic backgrounds are better at influencing their health behaviors.

Second, we recruit our medical students specifically with a focus on increasing the number of physicians in Inland Southern California in primary care and short-supply specialties. Our region has just 40 primary care physicians per 100,000 people—far below the 60 to 80 recommended—and a shortage in nearly every kind of medical specialty. Students who have been heavily involved in service such as the Peace Corps, or who are engaged in community-based causes, are more likely to go into primary care specialties and practice in their hometowns.
Then, we teach our medical students an innovative curriculum. For instance, the Longitudinal Ambulatory Care Experience, called LACE for short, replaces the traditional “shadowing” preceptorship, where students follow around different physicians. Instead, our students participate in a three-year continuity-of-care primary care experience that includes a sustained mentor-mentee relationship with a single community-based primary care physician. In this experience, they “follow” a panel of patients and gain an in-depth understanding of the importance of primary care, prevention and wellness. Our approach also includes community-based research that grounds medical students in public health issues such as the social determinants of health, smoking cessation, early identification of pre-diabetic patients, weight loss management and the use of mammograms to detect breast cancer.

We try to remove the powerful financial incentive for medical students to choose the highest paying specialties in order to pay off educational loans. We do this with “mission” scholarships that cover tuition in all four years of our medical school. This type of scholarship provides an incentive for students to go into primary care and the shortest-supply specialties and to remain in Inland Southern California for at least five years following medical school education and residency training. If the recipients practice outside of the region or go into another field of practice before the end of those five years, the scholarships become repayable loans.

Third, we are creating new residency training opportunities in our region to capitalize on the strong propensity for physicians to practice in the geographic location where they finish their post-M.D. training. Responding to our region’s most critical shortages, we are concentrating the programs on primary care specialties like family medicine, general internal medicine, and general pediatrics, as well as the short-supply specialties of general surgery, psychiatry, and OB/GYN. We are also developing a loan-repayment program for residents linked to practice in our region.
Ultimately, we hope our ideas for how to change health care will succeed and be adopted by others. It might take 30 years, but we believe what we are doing at the UCR School of Medicine will change the face of medical education in the U.S.

This article was written in partnership with Zocalo Public Square.
RIVERSIDE, Calif. — In the Inland Empire, an economically depressed region in Southern California, President Obama’s health care law is expected to extend insurance coverage to more than 300,000 people by 2014. But coverage will not necessarily translate into care: Local health experts doubt there will be enough doctors to meet the area’s needs. There are not enough now.

Other places around the country, including the Mississippi Delta, Detroit and suburban Phoenix, face similar problems. The Association of American Medical Colleges estimates that in 2015 the country will have 62,900 fewer doctors than needed. And that number will more than double by 2025, as the expansion of insurance coverage and the aging of baby boomers drive up demand for care. Even without the health care law, the shortfall of doctors in 2025 would still exceed 100,000.

Health experts, including many who support the law, say there is little that the government or the medical profession will be able to do to close the gap by 2014, when the law begins extending coverage to about 30 million Americans. It typically takes a decade to train a doctor.

“We have a shortage of every kind of doctor, except for plastic surgeons and dermatologists,” said Dr. G. Richard Olds, the dean of the new medical school at the University of California, Riverside, founded in part to address the region’s doctor shortage. “We’ll have a 5,000-physician shortage in 10 years, no matter what anybody does.”

Experts describe a doctor shortage as an “invisible problem.” Patients still get care, but the process is often slow and difficult. In Riverside, it has left residents driving long distances to doctors, languishing on waiting lists, overusing emergency rooms and even forgoing care.

“It results in delayed care and higher levels of acuity,” said Dustin Corcoran, the chief executive of the California Medical Association, which represents 35,000 physicians. People “access the health care system through the emergency department, rather than establishing a relationship with a primary care physician who might keep them from getting sicker.”

In the Inland Empire, encompassing the counties of Riverside and San Bernardino, the shortage of doctors is already severe. The population of Riverside County swelled 42 percent in the 2000s, gaining more than 644,000 people. It has continued to grow despite the collapse of one of the country’s biggest property bubbles and a jobless rate of 11.8 percent in the Riverside-San Bernardino-Ontario metro area.

But the growth in the number of physicians has lagged, in no small part because the area has trouble attracting doctors, who might make more money and prefer living in nearby Orange County or Los Angeles.

A government council has recommended that a given region have 60 to 80 primary care doctors per

**Projected Shortages of Patient Care Physicians**

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<th>Year</th>
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(Source: Association of American Medical Colleges)
100,000 residents, and 85 to 105 specialists. The Inland Empire has about 40 primary care doctors and 70 specialists per 100,000 residents — the worst shortage in California, in both cases.

Moreover, across the country, fewer than half of primary care clinicians were accepting new Medicaid patients as of 2008, making it hard for the poor to find care even when they are eligible for Medicaid. The expansion of Medicaid accounts for more than one-third of the overall growth in coverage in President Obama’s health care law.

Providers say they are bracing for the surge of the newly insured into an already strained system.

Temetry Lindsey, the chief executive of Inland Behavioral & Health Services, which provides medical care to about 12,000 area residents, many of them low income, said she was speeding patient-processing systems, packing doctors’ schedules tighter and seeking to hire more physicians.

“We know we are going to be overrun at some point,” Ms. Lindsey said, estimating that the clinics would see new demand from 10,000 to 25,000 residents by 2014. She added that hiring new doctors had proved a struggle, in part because of the “stigma” of working in this part of California.

Across the country, a factor increasing demand, along with expansion of coverage in the law and simple population growth, is the aging of the baby boom generation. Medicare officials predict that enrollment will surge to 73.2 million in 2025, up 44 percent from 50.7 million this year.

“Older Americans require significantly more health care,” said Dr. Darrell G. Kirch, the president of the Association of American Medical Colleges. “Older individuals are more likely to have multiple chronic conditions, requiring more intensive, coordinated care.”

The pool of doctors has not kept pace, and will not, health experts said. Medical school enrollment is increasing, but not as fast as the population. The number of training positions for medical school graduates is lagging. Younger doctors are on average working fewer hours than their predecessors. And about a third of the country’s doctors are 55 or older, and nearing retirement.

Physician compensation is also an issue. The proportion of medical students choosing to enter primary care has declined in the past 15 years, as average earnings for primary care doctors and specialists, like orthopedic surgeons and radiologists, have diverged. A study by the Medical Group Management Association found that in 2010, primary care doctors made about $200,000 a year. Specialists often made twice as much.

The Obama administration has sought to ease the shortage. The health care law increases Medicaid’s primary care payment rates in 2013 and 2014. It also includes money to train new primary care doctors, reward them for working in underserved communities and strengthen community health centers.

But the provisions within the law are expected to increase the number of primary care doctors by perhaps 3,000 in the coming decade. Communities around the country need about 45,000.

Many health experts in California said that while they welcomed the expansion of coverage, they expected that the state simply would not be ready for the new demand. “It’s going to be necessary to use the resources that we have smarter” in light of the doctor shortages, said Dr. Mark D. Smith, who heads the California HealthCare Foundation, a nonprofit group.

Dr. Smith said building more walk-in clinics, allowing nurses to provide more care and encouraging doctors to work in teams would all be part of the answer. Mr. Corcoran of the California Medical Association also said the state would need to stop cutting Medicaid payment rates; instead, it needed to increase them to make seeing those patients economically feasible for doctors.

More doctors might be part of the answer as well. The U.C. Riverside medical school is hoping to enroll its first students in August 2013, and is planning a number of policies to encourage its graduates to stay in the area and practice primary care.

But Dr. Olds said changing how doctors provided care would be more important than minting new doctors. “I’m only adding 22 new students to this equation,” he said. “That’s not enough to put a dent in a 5,000-doctor shortage.”
In Search of More Primary-Care Doctors

Amid a looming shortage of primary-care doctors in the U.S., medical schools and innovators try to entice more students to enter the field.

By BARBARA SADICK
Nov. 17, 2013 4:07 p.m. ET

Janine Knudsen, a third-year student at Harvard Medical School's Center for Primary Care, is passionate about becoming a primary-care physician.

She is convinced that the U.S. is moving toward a health-care system that will put a much higher priority on keeping people healthy and out of the hospital, and that the primary-care doctor will play the leading role in this transformation.

"I see primary-care medicine as the most exciting field in medicine today," the 25-year-old Ms. Knudsen says, "and I'm thrilled to be on what I believe is the cutting edge of change."

If the U.S. has any hope of putting a dent in what is expected to be a huge shortage of primary-care physicians over the next decade, medical schools will have to find and train a lot more people who think like Ms. Knudsen.

The Association of American Medical Colleges, or AAMC, predicts that by 2020 the U.S. will be short more than 45,000 primary-care doctors—those who practice internal medicine, family medicine and pediatrics. With millions more patients expected to be seeking a doctor because of the Affordable Care Act and 10,000 Americans turning 65 every day for the next two decades, demand for these physicians is outstripping supply. Yet only about 20% of medical residents go into primary care, according to the AAMC.

To help address the doctor shortage and channel more U.S. students away from specialty fields, some medical schools are adding community-based primary-care training programs, and at least 17 new medical schools have opened since 2005, some committed to training only primary-care doctors, or PCPs. Several of the newer schools aim to educate PCPs specifically for underserved communities, and they use financial incentives such as loan forgiveness to make that happen.
According to Russell S. Phillips, director of Harvard's Center for Primary Care, founded in 2010, the U.S. needs to move away from a system that rewards procedures and in which PCPs have been devalued, and instead encourage students to view primary care as a route to creating a more effective health system.

Dr. Phillips and Leonard Feldman, director of the new Medicine-Pediatrics Urban Health Residency Program at Johns Hopkins, say their programs were created with the hope that the doctors they train will become leaders and role models in this new system, where the primary-care physician will collaborate with nurse practitioners, physician assistants, social workers and other professionals to keep people well, taking into consideration the patient's cultural background and social experiences, among other things.

**Changing the Culture**

Of course, changing the way primary care is delivered—and perceived—isn't going to be easy.

One of the reasons the U.S. is facing a shortage of PCPs is because the brightest students are often told they're too smart not to specialize, and that attitude is reinforced throughout their medical training. Hospital culture often depicts PCPs as paper-pushers and gatekeepers to the world of specialists.

PCPs also earn substantially less than medical specialists, and even those who want to work in primary-care medicine are often deterred by the prospect of paying back a huge amount of student-loan debt. According to the AAMC, the average student debt upon graduation from medical school is more than $166,000, and although loan payback and forgiveness programs exist, there isn't enough money to go around.

George Thibault, president of the Josiah Macy Jr. Foundation, an organization working to improve health care in the U.S., says that if the U.S. wants to produce more primary-care doctors, especially those who are willing to practice in disadvantaged and underserved areas, medical schools may need to change the way they select students. He says students who have strong ties to their community, want to form long-term relationships and have a commitment to public service are more likely to choose primary care than other students.

"All medical schools can train dedicated, excellent community-driven PCPs," Dr. Thibault says, "but some have it as their mission and others don't."

The University of California Riverside School of Medicine, which enrolled its first 50 students this year, is one that does. The school's mission is to train physicians who will remain in the community, where there is a shortage of doctors.

"Over 90% of medical training in the United States takes place in academic medical centers," says G. Richard Olds, the founding dean at Riverside, "but if we want students to go into primary care, we have to push training out into the community with a public-health agenda."
Like Dr. Thibault, Dr. Olds believes changes in the way medical students are selected will make for better PCPs. Grades and test scores, he says, can no longer be the exclusive criteria for entry into primary care. "I'd even argue," says Dr. Olds, "that those with the highest grades and Medical College Admission Test scores may not make the best doctors." Riverside seeks students with public-service work experience and those from disadvantaged backgrounds who are likely to return to their communities to practice.

Too Little, Too Late?

Central Michigan University College of Medicine, meanwhile, is relying on financial incentives to help it address the physician shortage in the central and northern parts of the state. Some 80% of the students in its inaugural class of 64 this year grew up in remote and rural areas of Michigan, and much of the training takes place in the community. Ernie Yoder, the founding dean, says the community has agreed to pay back student loans if doctors settle where the state has the greatest need.

Dr. Olds believes that society ultimately will put a greater value on PCPs, and that their earnings eventually will reflect that.

The tide will turn, agrees Colleen Christmas, director of the internal residency program at Johns Hopkins Bayview Medical Center, because a strong primary-care network can reduce costs. She says a recent study by Johns Hopkins researchers showed that with each 1% increase in the proportion of primary-care physicians, an average city will have 503 fewer hospital admissions, almost 3,000 fewer emergency-room visits, and 512 fewer surgeries annually.

Although medical-school enrollment rose this year to a record 20,055, and more students chose primary-care residencies this year than last, Dr. Thibault says the U.S. has to do more to solve its primary-care problem, such as making better use of nurse practitioners and physician assistants, offering better reimbursement for primary care and creating more residency slots in primary-care specialties.

Many medical educators and innovators agree that efforts to entice more students into primary care will be fruitless unless there is an increase in the number of federally supported medical residencies—the three to seven years of on-the-job training that medical-school graduates must complete before they can practice independently.

Atul Grover, the AAMC's chief public policy officer, says if the U.S. doesn't act, the country will end up not having enough training places for the doctors coming out of medical school.

Ms. Sadick is a writer in New York. She can be reached at reports@wsj.com.
UC Riverside Med School seeks out, fast-tracks local med students to keep new doctors in region

Medical student Crystal Deedas leans over and peeks into the ears and noses of pint-sized patients she’s caring for during her rotation at the Riverside Medical Clinic.

"Does this hurt?" she asks an 8-year-old boy visiting the clinic with his mother.

"What about now?" she says, as she further examines his ear.

There’s nothing unusual about a medical student, such as Deedas, doing supervised work on real-life patients. That’s all part of the clinical rotation experience required by medical schools. But what is unique is that Deedas is seeing patients in her first year of medical school. Typically, med students wait until their third year before getting such clinical experience.

Deedas, of Riverside, is part of the second class to enroll at the new University of California Riverside School of Medicine. The school opened last summer, in large part, to address the growing doctor shortage in the Inland Empire.

“We need physicians," says Dr. Ravi Berry, a pediatrician at the Riverside Medical Clinic who mentors Deedas. "If we grow our own they stay in the area."

To combat that dearth of doctors, administrators at UCR’s School of Medicine have created a novel program aimed at attracting home-grown med students, training them and then keeping the newly-minted doctors in the region.

“We have to provide for the physician manpower for inland Southern California. We also have to train doctors that are going into the fields that society needs," says Richard Olds, dean of the School of Medicine and UCR vice chancellor of health affairs. "We want the physicians that we train to be reflective of the cultural, ethnic and economic diversity of our region and we want to improve the health of the community we serve."

And key, he says, is to attract and enroll local students.
"About 40 percent of the decision where doctors practice is based on where they come from, their family connections, where they were born, went to high school and went to college," Olds says.

To find those candidates, he says, admissions officers sift through a pile of applications in search of students who have local roots and community ties.

Olds says there were 5,600 applicants for the 50 seats in this year’s class. Only 10 percent of them were from the area. Still, administrators managed to fill more than half of the seats with local students, such as Deedas.

But the efforts don’t end there.

The other important factor in where a doctor ends up practicing is where they finish their training, Olds said.

So he aims to address that, too, by creating new residencies in the area.

This is the three to five year training that doctors get after they graduate from medical school.

But those offered at the UC Riverside Medical School veer from tradition, Olds says. Most residency programs, which provide doctors with three to five years of post-graduate clinical training, take place at university-run hospitals. UC Riverside doesn’t have its own med center, it instead collaborates with local hospitals and clinics to provide the training.

So far, 100 med school graduates are now enrolled as residents. Olds hopes the community training they’ll receive will further embed the young doctors into the community.

That sounds appealing to Sarah Gomez, a Riverside local and second year student at UC Riverside Medical School. Gomez says she’s eager to apply for one of the local residencies once she graduates.

"You want to be somewhere where you can impact change," she says. "The easiest and best way to do that is in your home town."

One additional arrow in the UCR Med School quiver, Olds says, is financial assistance in the form of a dozen full-tuition scholarships for students who commit to practice medicine locally for at least five years.

Pediatric medical student Deedas is among this year’s recipients.

"It was a perfect match," she says. "I always intended on practicing near my family. And my family is in Riverside."
The UCR School of Medicine came into existence largely due to the support of the community it will serve. The pieces below provide information about the mission and vision of UCR School of Medicine and what work is being done to realize both.


Video piece about the School of Medicine produced by UC Riverside’s student newspaper, The Highlander: [https://www.youtube.com/watch?v=Ef0KYJE5GR8](https://www.youtube.com/watch?v=Ef0KYJE5GR8)

The Inaugural White Coat Ceremony for the UCR School of Medicine: [http://ucrtoday.ucr.edu/16926](http://ucrtoday.ucr.edu/16926)

A video and article describing UCR’s first White Coat Ceremony, wherein each student slips into the doctor’s white coat, held by a faculty member, to mark the beginning of four years of hard work.

The UCR School of Medicine: Year One [http://blog.pe.com/ucr-medical-center-year-one](http://blog.pe.com/ucr-medical-center-year-one)

This ongoing series being produced by the local Inland Empire newspaper follows five students in the inaugural class through their first year as medical students. Profiles of the five students paint a compelling picture of the future physicians the UCR School of Medicine will train.

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UCR’s School of Medicine: Training Doctors of the Future [http://www.youtube.com/watch?v=rfQCN9fMtk](http://www.youtube.com/watch?v=rfQCN9fMtk)

Hear from Founding Dean G. Richard Olds, faculty members and medical students explaining why the UCR School of Medicine exemplifies the innovation we need to answer the physician workforce needs our region faces.

Inspired to Serve [http://www.youtube.com/watch?v=1cVG5oznN5g](http://www.youtube.com/watch?v=1cVG5oznN5g)

Current medical students in the UCR/UCLA Thomas Haider Program share some personal reasons behind why they want to become the doctors our communities need.

Healing the Divide [http://ucrtoday.ucr.edu/4249](http://ucrtoday.ucr.edu/4249)

A closer look at the Inland Empire region and the critical health care access issues it faces.