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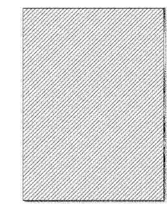

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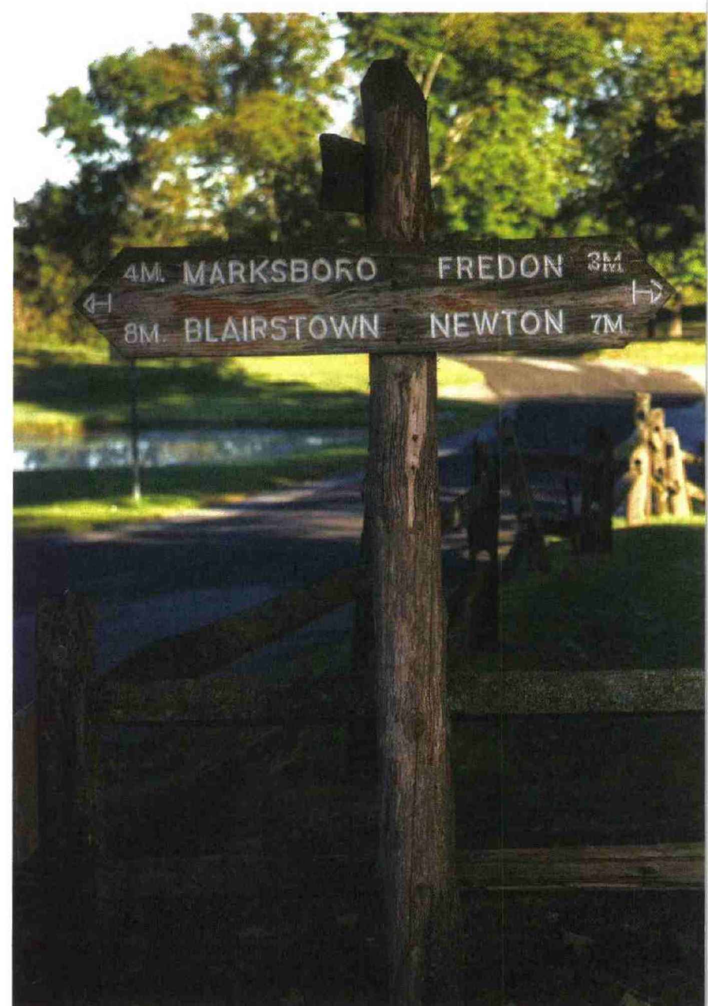

IS THERE A DOCTOR IN THE HOUSE?

New Jersey is facing a physician shortage—and there's no cure in sight.

BY **WAYNE J. GUGLIELMO**
PHOTOS BY MATT RAINEY

Dr. Gerald Cioce doesn't think of himself as a risk taker. On his way to becoming an interventional cardiologist, he followed what he calls "a very traditional" route: premed at Villanova University, medical school at Robert Wood Johnson (now part of Rutgers), and residency and fellowships at Tufts University in Boston and the University of Massachusetts. Even when the New Jersey native began looking for his first real job back home in 2008, he sought out practices that had established programs in his specialty. It seemed like the smart thing—the path many of his colleagues were taking.

But Cioce's job search presented him with a different kind of opportunity, one that was literally off the beaten path. In Newton, in rural Sussex County, the multimember Cardiology Associates was seeking an interventionalist to join its staff. Neither the practice nor the area had the services of a doctor in that specialty—one who treats heart problems using catheters, or thin, flexible tubes inserted in veins and arteries. And, though nearby Newton Hospital—renamed Newton Medical Center in 2011—had opened a diagnostic catheterization lab several years earlier, it was staffed by invasive cardiologists from the practice when they were not seeing their general cardiology patients. For patients requiring an emergency intervention such as a stent placement, the typical option was an ambulance or helicopter ride to Morristown Medical Center—which, like Newton, is part of the Atlantic Health System—about 35 miles away.

For Cioce, the opening at Cardiology Associates was a chance to build his own program in a region that desperately needed one. The prospect both excited and unnerved him. The practice's partners were as reassuring as they could be, but they too were treading on new ground. And when he mentioned the opening to his mentors in Massachusetts, they urged caution. "It sounds like a bit of a gamble," Cioce was told. Even his fiancée—whom he had met during his fellowship at UMass Medical Center, where she worked as a nurse—was not initially thrilled by the opportunity, although less because it was risky than because it was in the Jersey sticks.

The rural lifestyle is not for everyone, and that's a key reason many of the state's more remote areas have unmet specialty care needs. But this is just one manifestation of the widespread and growing shortage of doctors in New Jersey.

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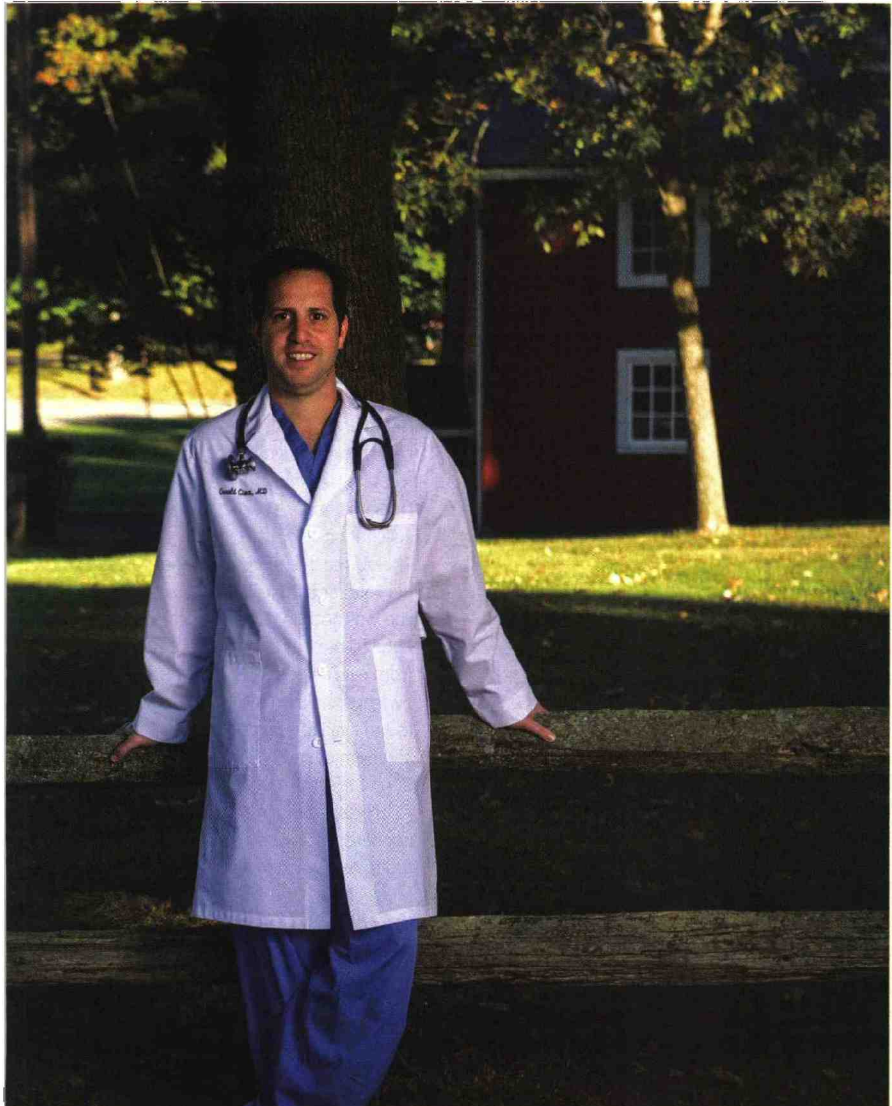

COUNTRY DOC: Dr. Gerald Cioce, an interventional cardiologist, went against conventional wisdom for newly minted specialists when he chose to practice in the rural Sussex County town of Newton. He's seen here at Water Wheel Farm in nearby Fredon Township.

The state's more populated and prosperous suburban areas have their own issue: a shortage of primary care physicians (PCPs), including family practitioners, general internists, geriatric doctors and general pediatricians. That shortage extends to some rural areas, too.

The shortfalls in primary and specialty care pose a major problem for New Jersey, one that's likely to get worse amid health care reform, a wave of retiring boomers and other demands on the health care system. What's more, the overreliance on specialists in many parts of the state tends to drive up the cost of health care here.

Several factors explain New Jersey's physician shortage, but the major reasons are simple: In primary care in particular, the state graduates fewer doctors per capita than neighboring states. We also have a harder time keeping the docs we train within our borders. And, unlike some other states, New Jersey does not have a proactive plan to reverse the latter

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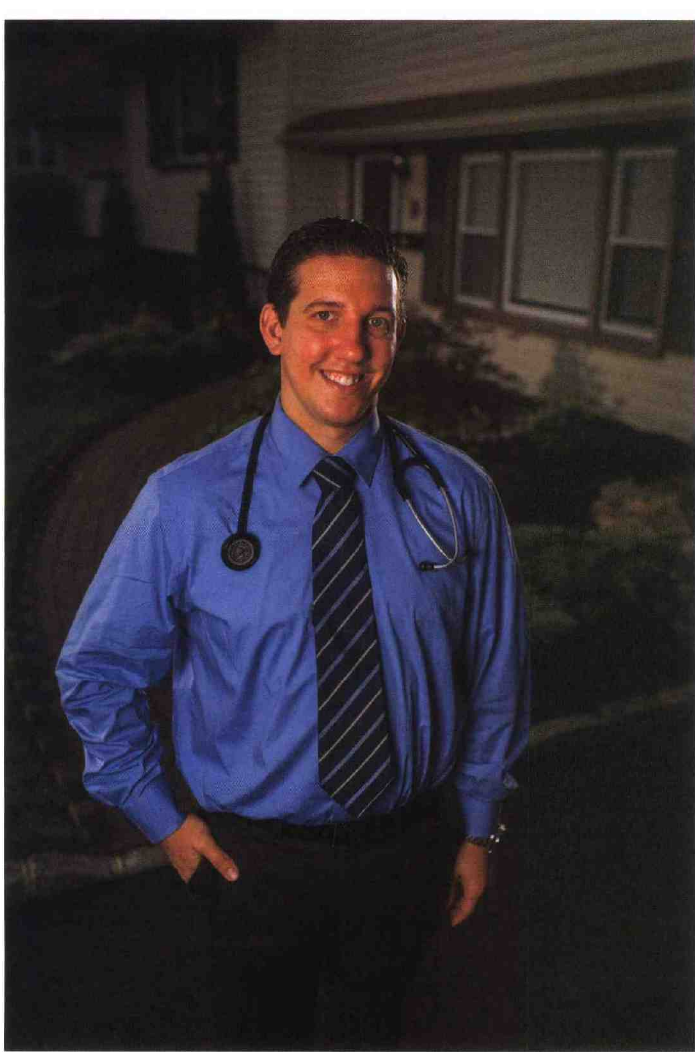

FAMILY FRIENDLY: With the support of Overlook Medical Center, Dr. Robert Lukenda, a family practitioner, was able to launch his own private practice in Cranford. He even makes house calls.

trend, experts say (see story, this page).

"The deeper we get into this workforce crisis, the more difficult it will be to fix," warns Ray Saputelli, executive vice president of the New Jersey Academy of Family Physicians.

LUCKILY FOR RESIDENTS of Sussex County, Gerald Cioce decided to fight the tide. He is enough of a Jersey guy to know that even the rural parts of the state are not that far from New York City or Philadelphia—to say nothing of Jersey's own population centers. He also determined that he would rather face an uncertain situation in Newton than end up being "another cog in the wheel" at an established interventional program elsewhere.

In the end, Cioce and his fiancée—the couple married in July 2009, shortly after he completed his fellowship—decided he should accept the offer from Cardiology Associates. Today, they live with their two children in Sparta Township, a half-hour's commute to the practice and to Newton Memorial, where Cioce is director of the low-risk cath lab. Two days a week, he works out of Morristown Medical Center, roughly the same commuting distance. "We took a little leap of faith, and it's worked out

Who'll Fix Our

Beginning in 2011, the second year of her family-medicine residency at CentraState Healthcare System in Freehold, Dr. Sara Leonard began receiving job solicitations from all over the country. The outreach intensified at the start of her third and final year, at which point she was getting "five to six calls a day, 15 to 20 e-mails and glossy brochures from everywhere." But apart from her own hospital and the occasional flyer listing available positions, usually in the southern counties, almost no solicitations came from New Jersey.

The seeming indifference puzzled Leonard, a New Jersey native committed to remaining in her home state, who knew about its acute doctor shortages. In the end, she was happy to accept a position at a practice affiliated with CentraState, where she had been a chief resident. "If not for the hospital system I'm in, I don't think I'd be in the state right now," says Leonard. "New Jersey almost lost me, and I'm one of its own."

Juan Soto, who handles the New Jersey and New York market for the national physician recruitment firm Merritt Hawkins, hears this sentiment a lot. "Among those on the hiring end," he says, "the assumption seems to be, if doctors have trained here, we don't need to go after them—they will come to us."

But hospitals and health systems can't bear all the burden of assuring that New Jersey trains and retains the doctors it needs.

Medical schools and residency programs also need to step up their game, experts say, especially in the area

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very well," Cioce says.

In Newton, the reluctance of many doctors—or their spouses—to take a similar leap of faith has resulted in a shortage of critical specialties, including anesthesiology, endocrinology, otolaryngology (ear, nose and throat), nephrology, obstetrics/gynecology, rheumatology, general surgery, and orthopedic surgery, to name those areas where the medical need is the greatest. "Sussex County isn't an exit off anything," says Mary Reasoner, director of business development and physician relations at Newton Memorial, whose job it is to

Physician Workforce?

of primary care. "There are people out there with an aptitude for medical school who have a strong sense of community and are likely to go into primary care," says Dr. David S. Kountz, vice president of academic affairs at Jersey Shore. "We need a new approach to identifying and admitting such students." Residency programs, Kountz says, also need to do more "to expose students to strong primary care role models. Get those students out into those [community] settings where we want them to practice."

The state government can also play a bigger role in addressing the doctor shortage, experts say, both in primary care and the specialties. Unlike other states facing similar challenges, New Jersey is largely missing in action on the issue, says Deb Briggs of the New Jersey Council of Teaching Hospitals. Confronting the shortage could fall to Mary E. O'Dowd, the commissioner of the Department of Health, but, says Briggs, O'Dowd has followed the lead of her predecessors and neither assumed a leadership role nor developed a comprehensive state health plan, one that would, among other things, correlate population needs with health workforce supply. O'Dowd declined a request to be interviewed for this article.

O'Dowd's office directed *New Jersey Monthly* to a Rutgers-based project called the NJ Health Care Talent Network, funded through a grant from the New Jersey Department of Labor and Workforce Development. But though this project collects some market data and talks to groups to discern trends in physician hiring, its major focus is on nursing and the allied health professions. Even the network's director, Dr. Padma Arvind, is puzzled "that the DOH isn't focusing on a lot of these workforce development issues, especially if there's going to be a huge demand for physicians down the road."

Some other states are doing a better job. In Massachusetts, for example, the Health Care Workforce Center, an agency within the Department of Public Health, looks at how well the existing physician and related workforce is meeting residents' needs, especially in primary care. It does this by collecting data on supply and demand, monitoring the impact of laws and policies on recruitment and retention, and initiating programs that address imbalances, among other actions. In 2008, Mississippi established the Rural Physicians Scholarship Program, which pays the education expenses of medical students who agree to practice in their rural home towns after graduation. And through its Pathways to Health Careers initiative, New Mexico has created a variety of strategies to identify, encourage and prepare young students for the health professions, including medicine.

New Jersey could learn from other states' efforts. At the same time, say experts, state officials who are interested in addressing the current and predicted physician shortages need to work more collaboratively with hospitals, medical schools and groups like the New Jersey Council of Teaching Hospitals

Says Briggs, "The state needs to be at the table."—WJG

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recruit new doctors to the facility. "Typically, doctors coming out of residency or fellowship who aren't married want to be closer to the city for its social life." Many also want to set up their practices in areas where population density and patient demand are higher, especially if they can't count on being the only game in town, like Cioce.

Other largely rural parts of the state are in the same boat. The state Office of Rural Health defines nine other counties as rural: Atlantic, Burlington, Cape May, Cumberland, Gloucester, Hunterdon, Ocean, Salem and Warren. In these counties, the most widespread shortages are in neurosurgery and the pediatric subspecialties (adolescent medicine, gastroenterology, nephrology and others), according to a workforce report issued in 2009 by the New Jersey Council of Teaching Hospitals (NJCTH), a research and advocacy group. Specialties identified as being in significantly short supply include dermatology, emergency medicine, hematology/oncology and neurology. Overall, the NJCTH projects that by 2020, the state is likely to need an additional 1,800 specialists and 1,000 PCPs beyond its current academic pipeline.

In South Jersey, Clare Sapienza-Eck is fighting the tide. Part of her job at the recently formed Inspira Health Network—the result of a merger late last year between South Jersey Healthcare in Vineland, (Cumberland County) and Underwood Memorial Hospital in Woodbury (Gloucester County)—is to assist practices in the community to recruit new doctors, especially in the hard-to-find specialties. To date, her biggest recruiting challenge has been finding an otolaryngologist. "It took me five years to finally get someone," she says. Other specialties that have proven challenging are gastroenterology, urology and several of the surgical subdisciplines.

One of Sapienza-Eck's recruitment tools is a forgivable loan—a kind of grant with conditions, typically paid out over time. Practices in search of new doctors can use such loans in any number of ways: to supplement salary, provide signing or retention bonuses, or help defray the costs associated with a new hire, for example. Inducements of this kind must meet the federal government's fair-market test, meaning Sapienza-Eck can't pay a doctor more than he or she is likely to get paid elsewhere. (Bonus plans linked to productivity must also meet this standard.) And before any incentive can be offered, lenders must document to federal regulators that a gap in care actually exists, something most hospital systems use an outside, independent company to do.

Using this incentive, Sapienza-Eck recruited urologist Sanjay Kasturi to the Vineland area. This past June, at Thomas Jefferson University in Philadelphia, Kasturi completed with distinction his fellowship in robotic surgery and endourology, a sub-branch of urology that deals with the advanced treatment of kidney stones, among other urinary tract diseases. Raised in Eastampton Township in Burlington County, Kasturi had pondered returning to South Jersey but, in truth, he had done so well in school

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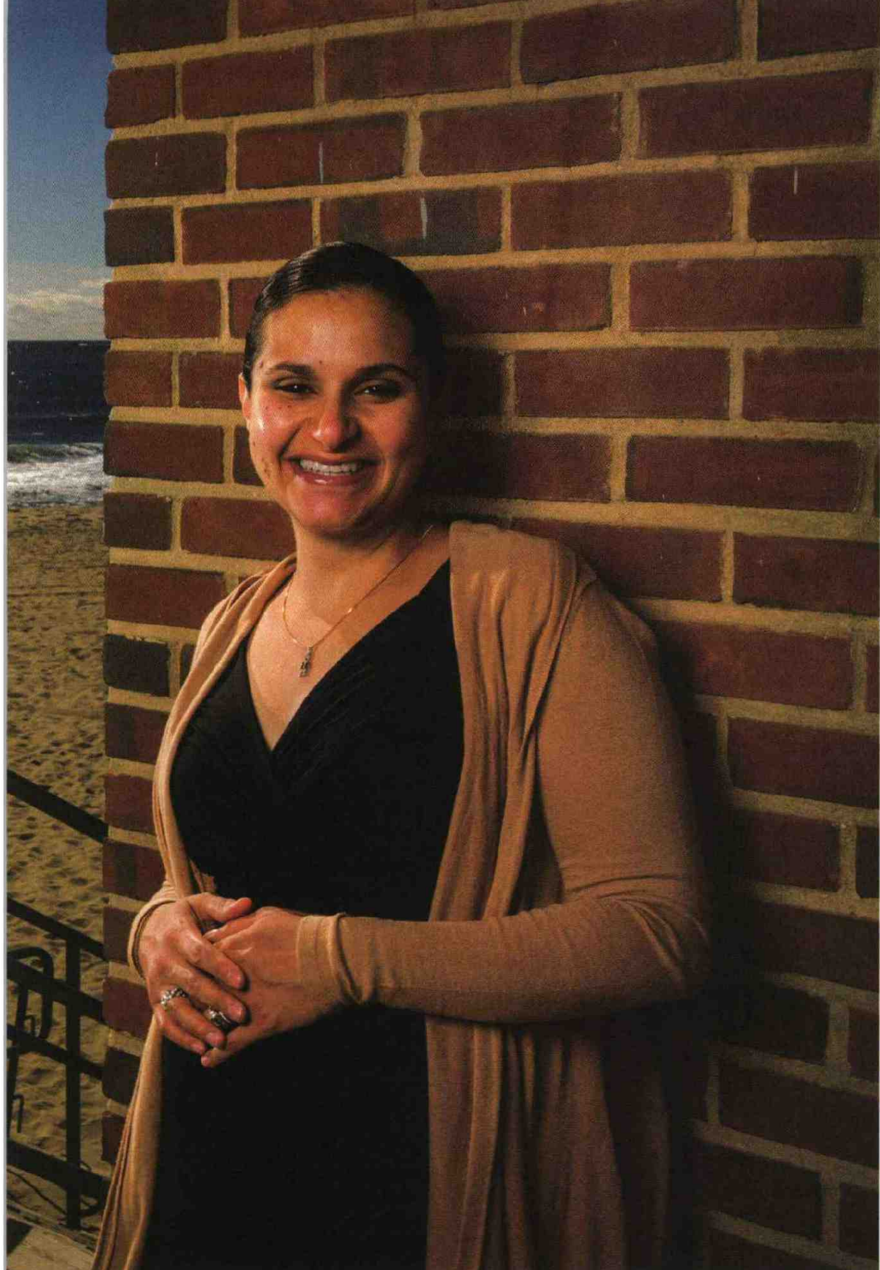

and training—including the University of Pennsylvania, where he completed his residency—that he could have gone anywhere. His fellowship mentors at Thomas Jefferson, though, knew many of the partners at the largest urology practice in the region, Delaware Valley Urology, which has offices across five South Jersey counties. Besides being a "perfect fit" for him, said his mentors, the opportunity would address the needs of the South Jersey community, which did not have a doctor with Kasturi's robotic-surgery training.

Officials at Inspira also rec- *(Continued on page 142)*

SHORE THING: Dr. Abeer Elessawi maxed out her credit cards to get her internal medicine practice going in Neptune. It's hectic, but Elessawi still finds time to visit Asbury Park, a favorite destination.

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ognized a good fit. With Sapienza-Eck as lead, they offered Delaware Valley Urology a forgivable loan, part of which is going to supplement Kasturi's salary and part to fund a retention bonus to be paid over three years, the term of his contract with DVU.

Kasturi took the bait and, with help from other Delaware Valley doctors who join him in his Vineland office on a rotating basis, has begun to build his practice. "My goal is to provide general urologic services," he says, "and also to develop a robotic center of excellence at Inspira Vineland," which has state-of-the-art robotic facilities. He recently performed the hospital's first robotic-assisted laparoscopic partial nephrectomy, a minimally invasive surgical treatment for the most common type of kidney cancer in adults. As the area's only fellowship-trained robotic surgeon, he thinks he has a decided edge: "I have already done robotic procedures under very watchful eyes." (Other surgeons doing similar procedures have honed their skills "on the fly," Kasturi says.)

Many of these rural areas are also facing primary care shortfalls, but this problem hits hardest in cities and suburbs. (In low-income urban areas, language barriers, lack of insurance and other access-related issues often pose a bigger problem than the total number of physicians.) According to another report by NJCTH—this one focused on primary care and released earlier this year—"Northern New Jersey has a greater need of family physicians...than Southern New Jersey," with the biggest shortfall showing up in densely populated and affluent Bergen County.

That the doctor mix in places like Bergen County tilts decidedly toward specialty care doesn't surprise Deborah S. Briggs, NJCTH president and CEO. "Experts who look at such demographic data say it isn't unusual for the more affluent citizens of a state to more freely move between specialists," she says. In other words, suburbanites tend to support a specialty-driven health care environment.

Dr. Susan T. Kaye, medical director at Atlantic Health System and chair of the Family Medicine Department at Overlook Medical Center in Summit, adds: "Many people [in suburban New Jersey] have an audiologist, an endocrinologist, an orthopedic surgeon...so that in much of New Jersey and the New York metro area we have a specialty-to-primary-care ratio that's extremely high." Kaye further notes that this trend "drives up the cost of care."

According to current estimates, 70 percent of all New Jersey doctors are specialists. The actual gap is likely much wider, however, since many doctors who are trained as PCPs do not practice in an ambulatory or outpatient setting such as a private office. Instead, they work in emergency rooms or as hospitalists, specialists who treat seriously ill patients in the hospital.

The squeeze on primary care has taken its toll. New Jersey ranks 14th on a list of states ranked by the number of active PCPs per 100,000 population, trailing neighbors Pennsylvania, New York and Connecticut. At the top of the list, compiled by the Association of American Medical Colleges (AAMC), is Massachusetts, which has 132 active PCPs per 100,000 population. New Jersey has 99.6. (At the bottom of the list, Mississippi has 63.6.)

To add to the imbalance, fewer medical students today are choosing primary care. Nationally, an estimated 21 percent of internal medicine residents go on to become generalists (doctors who see adult patients with a range of health issues), according to the American Board of Internal Medicine. Most of the rest choose a more lucrative internal medicine subspecialty, such as cardiology or gastroenterology. The trend away from primary care poses an extra challenge for federal health care reform, which beginning next year will funnel millions of formerly uninsured patients into the system. The trend also runs counter to new practice models such as the patient-centered medical home, which envisions a team-based approach to health care delivery, using medical assistants, nurses, pharmacists, social workers and others, typically led by a PCP.

New Jersey faces even bigger challenges than some other states. For one, the state trains fewer primary care graduates as a percentage of its population than nearby Pennsylvania and New York, according to a 2011 report by the AAMC. (For New Jersey, the number is 15.7 pri-

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mary care grads per 100,000; in New York, it's 32.4.)

New Jersey also has trouble retaining physicians. The NJCTH's 2012 Resident Exit Survey reports, "41 percent of respondents with confirmed practice plans were remaining in the state, compared with 48 percent nationally." Among general internists, the in-state retention rate drops to an anemic 36 percent.

Why the stampede out of the Garden State? Economics is a big part of the answer.

Although their training tends to take less time than that of specialists, primary care graduates typically leave school with $150,000 or more in student debt. This hefty burden is compounded by the comparatively lower starting salaries in the Eastern United States for beginning PCPs. According to a 2013 survey by the Medical Group Management Association, a trade group for medical practice managers, the median salary for a beginning family physician here is a tick over $163,000, compared with roughly $176,000 in the Midwest or West. This salary gap widens when comparing beginning PCPs with specialists. A cardiologist starting out here can expect to make about twice what his or her primary care colleague earns. Add to this the high costs of living and running a practice in New Jersey, and it is little wonder that so many new family doctors, general internists, geriatricians and pediatricians are fleeing the state.

In Northern New Jersey, the current shortfall of family physicians is estimated at 991, based on demographic and other data compiled by the NJCTH. Statewide, geriatricians (doctors who treat older adults) are also in short supply, perhaps by as much as 180 doctors, according to a 2009 NJCTH survey. These shortfalls add up. "Looking from a purely primary care perspective, we forecast a shortage by 2020 of between 3,500 to 4,000 doctors," says the NJCTH's Briggs. "Our primary care shortage is acute."

New Jersey's larger hospital systems are trying to reverse this trend, at least in their own catchment areas, or service regions. Most are offering incentives to attract and retain family doctors, general internists and other PCPs, whether they want to start their own practices or join existing ones.

Family physician Robert Lukenda, 30, who practices in Cranford, in Union County, is a beneficiary of this assistance. Born and raised in neighboring Linden, Lukenda was a biological science major at Rutgers when he decided on a career in medicine. After Rutgers, Lukenda entered the NYIT College of Osteopathic Medicine in Old Westbury, New York, where he discovered his attraction to family medicine. "I'm a big believer in primary and preventive medicine," says Lukenda. "I also liked the variety of family medicine—it's all the specialties in one—and the fact I could see anyone, from birth to 100 years old."

New Jersey is 14th on a list of states ranked by the number of active primary care physicians per 100,000 population.

Three years of residency in family medicine followed at Overlook Medical Center, where Lukenda was the chief resident during the 2010-2011 academic year. By that point, he had also come to another decision, one that is becoming increasingly rare. "I wanted to start my own practice and have input from the beginning on how it was run," he says. But Lukenda was already shouldering more than $200,000 in student debt, and he knew that his income as a family practitioner in New Jersey was going to be significantly less than that of some of his fellow residents who intended to practice in the Midwest and elsewhere. During his residency, he had also witnessed enough private practices to know that, for the solo practitioner just starting out, cash flow can be irregular, exacerbated by the time it takes many insurance companies to reimburse providers for their services.

Lukenda had been an outstanding resident, though, and Overlook was eager to have him set up shop nearby, especially given the local need for primary care services. To start him on his way, the hospital offered him a one-year income guarantee, which was based on the average salary for a family practitioner in his region. Once in effect—his practice opened January 2012—the agreement required that he submit all his practice-related bills to the hospital; if his monthly expenses exceeded his expected income, Overlook, also part of Atlantic Health System, would make up the difference. The hospital also agreed to reimburse his lenders up to $100,000 over a four-year period—the term of his commitment to remain in the area—toward the repayment of his student loans. "It's not a complete repayment, but it does help out for a few years," Lukenda says. As for the income guarantee, his practice couldn't have survived his first year without it, he says.

Today, after nearly two years in practice, Lukenda sees an average of 20 patients a day. Mornings, he makes visits to the hospital and area nursing homes. And like an old-fashioned doctor, he makes home visits throughout the week, carrying, yes, a black bag. There are stressful days, to be sure, and his practice is not yet at full capacity—25 to 30 patients a day would be optimal—but he feels good about the decisions he's made to date. "I'm happy, my practice is still growing, and my patients are referring other patients. I'm probably doing something right."

Not every new doctor is quite as fortunate. And sometimes, as in the case of Abeer Elessawi, 35, an internist with her own practice in Neptune, in Monmouth County, the problem is simply a matter of timing.

Born in Hoboken, Elessawi is a first-generation Egyptian-American whose parents immigrated to the United States in the 1970s. After completing her residency in internal medicine at the Jersey Shore University Medical Center in Neptune in 2008, she worked for a year in another physician's practice, also on the Jersey Shore. But Elessawi wanted to be her own boss—it was, after all, one of the reasons she went into medicine—and the fact that she couldn't run things the way she believed they should be run was starting to grate.

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She wanted very badly to open her own practice, but the economics of any new venture looked grim. Like many of her colleagues, she was carrying a sizeable student-loan burden. Normally, such a debt should not have been a major hurdle for a PCP interested in remaining in the hospital's catchment area. And in fact, to encourage residents and other doctors to do just that, Jersey Shore, part of Meridian Health, had initiated a loan repayment program, much as the other large systems had started doing. But the program was for residents beginning with the 2009 graduating class; Elessawi had graduated the year before and was ineligible.

Elessawi's bad timing didn't end there. Securing a private loan during this period, she found, was also a challenge. Still wary after the near collapse of the U.S. economy, banks were in no rush to give a debt-saddled, relatively inexperienced physician much in the way of a business loan. The risk was simply too great, especially since, as Elessawi was told, 50 percent of new businesses fail, even those headed by a doctor. She was determined, though. After securing a line of credit and some "tiny business loans," which she augmented by "maxing out my credit cards" to pay for utilities, employee health insurance and other office-related expenses, she knew she had enough of a financial grubstake to move forward. "I combined it all and slowly built my practice," she says.

Today, Elessawi's Internal Medicine Institute of New Jersey is at full capacity. Elessawi employs two medical assistants, one who also functions as the office manager, and a phlebotomist, the allied health professional who draws blood for office-based tests. The search for a partner is also under way, although it's been hard to find someone up to the task, given Elessawi's hectic schedule of office hours and house calls, along with hospital, nursing home and hospice visits.

At some point, Elessawi says, "we may have to be under some bigger umbrella"—a hospital, perhaps—"just to cut back on our overhead." For now, though, she loves what she does: "I can't explain the attachments you develop with patients. They just rely on you—and you can't let them down." ■

Wayne J. Guglielmo reports on health care issues for New Jersey Monthly.

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