JOE SCHERGER

November 12, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: Your date of birth?

Scherger: August 29, 1950.

Mullan: It is the twelfth of November, 1996, and we're sitting in the Department of Family Medicine at the University of California-Irvine (CCM, for the cognisenti), in Anaheim, California. Where are we, actually?

Scherger: Orange, technically.

Mullan: Orange. The town? The county?

Scherger: In the town.

Mullan: In the town of Orange, California, on a sunny, hazy November afternoon. We are five stories high in a glassy office building, looking out at another glassy office building, in what

has to be one of the more business-ized health science campuses that I've encountered. Before we talk about Joe Scherger, why don't you tell me just a little about--if you know, because Dr. Scherger is very new on the job--of the campus. Where are we located?

Scherger: If you look out of my window, you can see the Matterhorn. You can see Anaheim Convention Center, and you can see the Crystal Cathedral.

Mullan: What is Crystal Cathedral?

Scherger: The Crystal Cathedral is one of the largest Christian non-denominational churches around that probably raises more money than any individual church, maybe except for some of the South. Orange County is a very Bible Belt type of country, so that happens to be just a few blocks from here, with Disneyland being about a mile, mile and a half away.

Mullan: The Matterhorn is Disneyland?

Scherger: The Matterhorn is in the center of Disneyland, right. So Disneyland and its surroundings are very close by. The University of California-Irvine has a split campus. The college

campus is about twenty minutes away to the south and west, in the town of Irvine. It's a beautiful campus where the medical school is housed, and the basic science departments are housed. Then the University of California-Irvine Medical Center, is right next door to us. This glass building is because of overflow needing office space from the actual medical center. The medical center was originally the county hospital of Orange County and was purchased by the University of California during the 1970s.

Mullan: It was purchased from the county?

Scherger: Yes.

Mullan: It dates back. It's not too old itself, it doesn't look like.

Scherger: In the 1940s, California built a large number of county hospitals, and many of them housed family practice residency programs, such as in Santa Rosa, San Bernardino, Ventura. It happens to be that the county hospital of Sacramento was purchased by the University of California-Davis, and became the University of California- Davis Medical Center. The University of California-Irvine purchased its county hospital, and San Diego did the same thing.

So these urban county hospitals, which would pre-date World War II, now, of course, they've been expanded upon greatly, and very little of the original building still exists. Some does, but the medical center, with the money of post-World War II, much of the construction was done during the 1960s, seventies, and eighties, to some degree.

Mullan: So it's a comprehensive general hospital, with the clinical departments based there?

Scherger: Yes.

Mullan: And family medicine is off campus. Are other departments off campus?

Scherger: Yes. There are other clinical departments that have moved over into this building, two blocks away, as adequacy of space in the hospital for clinical departments is limited.

Mullan: So this doesn't represent a particular prejudice against family medicine. They won't let you on campus, as it were?

Scherger: No.

Mullan: Good. All right. Well, let's start back. We've jumped way ahead in the story to your new appointment of a week or so. But let's talk about Joe Scherger, from the beginning. Where are you from?

Scherger: I'm from a small town in Ohio, called Delphos, which is in the northwestern quadrant of Ohio, flat, breadbasket country. Nearest city, fifty miles away, was Fort Wayne, Indiana. Delphos is halfway between Toledo and Dayton, if you wanted to locate it in Ohio.

My dad was a small-town banker. He was president of the People's National Bank of Delphos, Ohio, as was his dad before him. I'm the third of four children in a German Catholic family. German Catholics dominate the town. Delphos was founded by a priest and a group of German Catholics, leaving Germany during the financial hard times and religious persecution that was occurring in the 1830s, 1840s. They came down the St. Lawrence Seaway and settled throughout the Midwest, including founding the town of Delphos in Iroquois Indian country, around 1850. All of my relatives are from there.

My great-great-grandparents were married in Germany, and my great-grandmother was one of the original people born in Delphos, Ohio. So those are my roots, and being born in 1950 and educated in the sixties, like many of my generation, only a few stayed in

the town, so it was a time in the sixties where in small towns in Ohio, all of sudden there was an out-migration of college-educated youth.

Mullan: Did any of your family stay in Delphos?

Scherger: My parents still live there half of the year, and I have two brothers, one nine years older-- a psychologist, and one six years younger--an obstetrician/gynecologist, in the town of Lima--not to be confused with Lima, Peru, but spelled the same--in Ohio, which is fifteen miles away. That's a small city of about 35,000 people.

Mullan: So there are some roots still in the vicinity, anyway.

Scherger: Yes.

Mullan: What was growing up in Delphos like, as a kid in the fifties?

Scherger: It was very traditional American early days. I remember our first television. I remember the cars of the fifties extremely well. I was an innocent, joyful child, rooting for either the New York Yankees or the San Francisco Giants

during Mickey Mantle and Willy Mays days. I always spent two weeks in the summer on the farm with my first cousin, getting a sense--oddly enough, I was called a city slicker, because I lived in town.

Mullan: This was a farm outside of Delphos?

Scherger: Yes. Half of the students in school were farmers, and the big school was the St. John's Catholic school, which dominated the town. We were a fanatic basketball town, much like the movie, "Hoosiers," and we really lived for the high school basketball season, and often that was very successful.

My dad liked to travel. He had hay fever in the end of August, and we did long car trips every year, so I actually saw the country, via the car, with family car trips the last two weeks of every August, and took pride in the fact that I had visited, by automobile trips, staying in AAA motels, almost every state in the Union by the time I graduated from high school. He hated the long winter, and we spent every other Christmas in Fort Lauderdale, Florida, and so a "Where the Boys Are" atmosphere. I had a sister three years older, who was attractive and active, and she and I had many memorable moments in Fort Lauderdale, growing up, over the Christmas time.

Mullan: Was family was Catholic? Practicing Catholic?

Scherger: Yes.

Mullan: Was that an influence in your youth, did you feel?

Scherger: Very strong influence. My mother went to church every day, as did her mother, and I grew up being educated by nuns, and I took it all very seriously.

Mullan: There was a Catholic school in the town?

Scherger: Yes.

Mullan: High school as well?

Scherger: Yes. Catholic high school. There was a very small public school, and I got in trouble, as a freshman in high school, because my first girlfriend was not a Catholic, and that created a lot of stress in my mother, in particular.

I consider myself a very mission-driven person, and it dates back early into my childhood. I took my Catholic education very seriously. The missions of missionary physicians, or missionary priests and others, was a pattern of commitment to kind of making

the world a better place that was instilled with me very young. While I rejected Catholicism as a dogma while in college, the same kind of mission and drive--my mother always assumed I would be a priest, because my personality of caring and saving souls, if you will, and those kinds of traits, were apparent early along, and she sort of had me pegged as the one son who was going to become a priest.

Mullan: When you say you rejected the dogma, you gave up the church?

Scherger: I went to a Catholic college. I was sort of encouraged to consider either Notre Dame or the University of Dayton, which is a Marionist college in Dayton, Ohio. It happens to be where my sister went, and my parents encouraged me to consider there, also. But I became a philosophy major in college, and as soon as I began to study my main interest, which was nineteenth century German philosophers, Fourbach's *Essence of Christianity*, and really began to learn the intellectual side of philosophy, I began to realize the mythology of established religions and rejected the dogma.

Mullan: You did go to the University of Dayton?

Scherger: Yes. I graduated the University of Dayton. I was there from 1968 to '71, the intense heyday of student activism. In Delphos, I was more into rock and roll and the Beatles, and it was sort of the innocent sixties of bell-bottom pants and some clothing, but it was really when I left home in 1968, continued my travels.

I was very lucky. In the summer of '68, my grandmother had died and left me some money in the stock market. I read a tip my dad brought home about a Canadian mining company, and invested the money, which tripled in a few months, and I cashed it out and went to Europe for the summer, with a Royal Academy European governments tour.

My leadership in speaking and many of the activities I do today without much anxiety date back to high school. I became president of the Student Council in high school, and gave lots of speeches and enjoyed it. I liked doing leadership activities and taking initiative.

I went to Europe the summer before I started college. Very quickly I got involved with the anti-Vietnam War movement, and joined the Appalachia Club, and we'd go down into Kentucky and work on weekends in the school. With my philosophy major and being liberal, I got very involved in social causes and humanism, and went through an existentialist period in my philosophy.

I spent the next summer in Mexico, studying Spanish and touring around, also. I chose in college not to do major leadership activities, but more grass-roots social activism. I got very active in our Experimental College, which was brand new.

Mullan: This was at Dayton?

Scherger: At Dayton, correct.

Mullan: In other words, anti-war activities or things that might have been more mainline radical were less your focus than service kinds of things?

Scherger: I went to the big march on Washington, with a half million people. I got, actually, very alarmed and concerned by the SDS, the Students for Democratic Society. I thought they were very angry, hardcore radical. I loved listening to Dick Gregory and a number of speakers, but I really drew the line for what my values were. I was part of an activity that we took over the administration building and shut down the school for a day at Dayton, and a few things like that, but I kept my nose clean.

I was a good student. I went to college--interestingly enough, I signed up for college in chemical engineering. My aptitude was always math and science, and I considered myself a

future scientist. Prior to going to Dayton, I got a National Science Foundation scholarship to go over to Ohio State and do some pre-college science preparation, and got very turned off to thermodynamics and physical chemistry, and came home with kind of a crisis of identity. I told my parents that I just found the sciences too impersonal.

My older brother, nine years older, had started in pre-med at Xavier in Cincinnati, and didn't like comparative anatomy, and ended up in psychology. I remember when that upset my parents, because they had an identity of my older brother becoming a doctor. I came back from Ohio State and told my parents I didn't think I was going to be a scientist, maybe I should be like Dick and become a psychologist, and they said, "The future in that is not that great. You ought to consider something else." I hated blood and guts, and the only thing that ever happened to me when I went to the doctor was get a shot, and the office smelled horribly like alcohol. But I thought, well, maybe I'd give it a try.

So, actually, I arrived at Dayton as a chemical engineering major, decided to take a job as a hospital orderly, to sample the medical environment, because I thought, "Well, medicine is the way you match science with humanity," and immediately fell in love with the health care environment. My job throughout my three years of college was as a hospital orderly, mostly on the graveyard night shift, 11 p.m. to 7 a.m., was just a great joy to

me. I told myself I was probably never going to happier in health care than as an orderly, because it was so much fun, and a lot of contact, not a lot of responsibility. All the doctors seemed worried and serious, where I was having just a great old time.

Mullan: This was in Dayton?

Scherger: This was in Dayton. So St. Elizabeth Hospital in Dayton, Ohio was my first health care job. I've kept my name badges of my health care career, which begins as "Joe Scherger, Orderly" and "Joe Scherger, Nurse Assistant II." And, actually, as a freshman medical student, I even continued to work as a nurse assistant, and that identity with nurses was very important later on.

Mullan: What happened with your major?

Scherger: I switched from chemical engineering to something called pre-medical studies, with a minor in philosophy. I decided to not waste time in college, although I loved it. I did the travel in the summer. I actually graduated in three years. Dayton was on a system that went from the end of August and finished at the end of April. And so I always took classes well

into the summer. Part of it was traveling and getting credit in Mexico for studying Spanish, for example, that I was able to graduate in three years. So, in '71, I finished.

Another piece about me, because of all the travel, I wanted to go to college either in California or New England. I had decided that those were the two areas of the country that fascinated me the most. My parents convinced me, and said that they'd support me to age twenty-one if I stayed in Ohio, so that was pragmatically why I went to Dayton, but I only applied to medical schools in New England and in California.

The California connection, my dad had one brother, who became a general practitioner. His name was Ed, a little older, he delivered me. After World War II, he came back to Delphos. But when I just four years old, in 1954, he and his wife, that he had met while in medical school in St. Louis University, moved to Southern California, the Los Angeles area, and set up a medical practice with his old lab partner. They were Scherger and Sauer, in West Covina, California. He never had children, and Ed and his wife, Polly--Ed's deceased, Polly's still alive--became an inspiration. We would visit them in California, and hence, I ended up at UCLA in 1971.

I almost went to medical school at Tufts. Of all the Boston schools, it had the social consciousness and the community medicine that interested me the most. By the time I was ready for medical school, there were two things I had decided. No more

grades. I had finished college with a 4.0 and didn't want to worry about another "A" in my education.

Mullan: Didn't want to spoil the record.

Scherger: Well, yeah, but I was very tired of that pressure. It was sort of like a winning streak. You know, you finish, and it's sort of like, are you going to break your winning streak? I was done with grades pressure. I was interested in liberal education philosophy, *Education as Ecstasy*, and at that time, many, if not most, of the medical schools were moving to pass/fail, and so I looked at those.

I was also very interested in medical schools that were involved with community medicine. Of the Boston schools, Tufts appealed to me the most. I was also interested in UCLA because of my uncle, primarily, and their pass/fail system, and Stanford, which had a very open elective curriculum at that time. So those were the schools that interested me the most.

Stanford rejected me. Tufts took me and sent me a letter saying the tuition was doubling, and don't count on any scholarship money, and UCLA accepted me, and that's where I went.

Mullan: How was it?

Scherger: Very positive. I loved my four years at UCLA. Again, in 1971, it was a time for open-mindness and change. We were all college students of the late sixties, and I immediately went to the Department of Preventive and Social Medicine, chaired by Lester Breslow, who had just stepped down as the health commissioner of California under Governor Pat Brown. He became one of my most important mentors, and ultimately dean of the School of Public Health at UCLA.

We started at UCLA a social medicine interest group that met at someone's house every month. Lester Breslow came. Bob Davidson, who was a resident at the time, came. Chuck Lewis came, along with students from different classes. But actually, it was the activism of my class--a black student named Cornelius Cooper, who's returned to Harlem Hospital and is in New York. Elizabeth Smith, who was a real activist. There were a lot of us who were very interested in community issues. We all worked at the Venice Family Clinic after hours. We actually created in the school the first required community medicine clerkship. It was only a two-week requirement, but we got it into the curriculum. Actually, ultimately became the primary care clerkship.

But UCLA--the pass/fail first two years was hard work, but very enjoyable. I got married at the time. I met my wife, who is still my wife now of twenty-three years. She was a respiratory therapist in the hospital where I was an orderly in

Dayton, Ohio, and we met just four months before I moved to California. She's three years older. She thought moving to L.A. was great, and when I said good-bye to my parents in my dark-blue Volkswagen bug, I drove down to Dayton, where she, in her orange bug, followed me out. We took an extended, joyful trip, and came to L.A. together.

Mullan: Bugging across country.

Scherger: Right. She continued to work as a respiratory therapist at what was then Cedars of Lebanon Hospital, ultimately became part of Cedars-Sinai, while I was in medical school. She became a registered nurse the last two years of my medical school. We had a wonderful time. We were two kids from Ohio, enjoying greater Los Angeles. We'd run into Mama Cass at Whiskey-a-go-go on Sunset Strip. It was four years of discovery, and a very, very pleasant time, a time in which I found a lot of mentors interested in the same things I was.

I didn't consider family medicine, actually, until my third year. The field was just barely getting started, and it was the counterculture alternative. I rejected the stereotypical departments of medicine, surgery, and peds, and wanted to do something that really represented true community medicine. When I was in my third year, and thoroughly enjoyed delivering babies,

and sewing up lacerations, and splinting casts, I shifted from what I thought was an internal medicine future into family medicine, because it was the way of not giving up any of the clinical areas of medicine, and being fully grounded as a community physician.

Mullan: What do you think the seeds of your activism, your community orientation, are? And then what the linkage is of that, in your mind, to family medicine.

Scherger: The seeds of my community activism came by just being very much a part of the values of our generation in the sixties.

Mullan: So there were plenty of folks, notwithstanding, celebrating numbers of people who on a personal level or a national level who were active. There were many who were not. So I'm always sort of curious. Clearly, the environment was more conducive to that, and we can look to colleagues and peers that have marched into the future, having apparently been infected, or impacted, by that. But all that said, there are still many who were not. I'm always curious about what the spark, what the tinder point was.

Scherger: Well, I think it goes back to my sort of Catholic missionary zeal of my childhood, where my fantasies of golden life were to be--I had a nickname of "Holy Boy" when I was a kid, and people would say, "What are you trying to be, a saint?" and I would say, "Well, you know, that's not up to me."

So I think that drive of being a people-oriented--you know, relieve human suffering, improve human existence, was really core to me, though I don't think I realized that as clearly as I might in retrospect. Those were the seeds.

Then, during college, what I was really interested in doing and spending my time, was to dealing with people and their problems. I felt that I had skills and a drive and a desire, that I could really make a difference with the quality and status of people's life in communities. I've always considered myself more of a sociologist and a social psychologist, even than a doctor. Those values are more core to me. When I'm often interviewed in family medicine, I often say my community medicine past is even longer than my family medicine past. So that's been really core to my existence. I think I credit my mother and father as much as anyone else for instilling those values into me.

Mullan: And the link to family medicine?

Scherger: Family medicine was a couple of things. It was the way of not giving up anything. It was the liberal education of medicine. You could continue to care for children and adults. You could do medical and surgical things. Obstetrics enchanted me. And so when I'd try to decide, "Is there any one of these areas that looms higher over others?" and if it would, I would have drifted into that, and it was, "No." Plus, I just saw the family physician as the ultimate community physician, and so that was the direction.

I got very excited when I began to look into family medicine in 1974. My first two years of medical school, I was a SAMA activist, and I read about the student health organization, and the new breed of physician. Marc Babitz was the guy. And Chuck Peyton, who I subsequently have become close friends with. They were my role models, and even youth.

Let's see, I don't remember when I first read, but I know about *White Coat, Clenched Fist,* and Lincoln Hospital. So I began to identify people, like yourself and Chuck and Mark, as role models of what it was about. I knew that I was interested in a more humanistic involvement in the community than the hardcore radical politics that some people were doing, like starting unions, health staff unions, and other issues I found interesting. But what happened to me is, my first two years of medical school I started our SAMA chapter. I was president of

our SAMA chapter. I was kind of in line to become a regional trustee.

Mullan: SAMA is Student American Medical Association?

Scherger: Right. A pre-date of AMSA. I was very involved in the convention. We got our plank for national health insurance. I remember debating Dan Ostergaard, who is now a close friend of mine, but he was anti-chiropractor. It was funny. In Delphos, Ohio, I grew up with chiropractors. I used to caddie for them on a golf course.

Actually, one little piece of my past, to just show how innocent I was in Delphos, is I thought I was going to be a golf pro until I was a sophomore in high school. I lived as a caddie, and my parents played golf all the time, and I was a small-town Ohio golfer until I entered my first state tournament as a youth, and shot about a 92, and that bubble was royally burst. I realized my future was not to be a golf pro.

Mullan: Do you play golf today?

Scherger: Occasionally. And it's funny. I play about twice a year in hospital benefits, and people look at me and say, "There's a good golfer inside of there." I once had a seven

handicap, which isn't fabulous, but it's pretty darn good. But now I enjoy the game, but the good golfer still lives inside of me. I'm not sure I'll ever devote as much to time to golf as I did.

The other piece that makes up my character, which I actually have had analyzed through some psychology work that I've done, is my older brother was the superstar athlete. He was the star pitcher of the baseball team, he was the leading scorer and forward of the basketball team, and he was quarterback of the football team. And I came along. It was nine years later, but in a small town, that wasn't a lot, and I was expected to be the next Scherger athlete. I was an enormous disappointment because I was not as skilled in any of those, and didn't have my brother's strong body.

The psychological trauma that disappointment, what my parents and others expected, shifted me to other missions. I had sort of told myself, "Well, I'm not going to be the athlete." I looked at other sports, like golf and tennis, but athletics was not what was important, and I was going to succeed and do things differently with my mind, and through leadership activities, do great things--I took an alternate path from my brother but with the same drive, if you will. I didn't realize that until one time recently, I went to a program called, "The Master Course," where they take you through your life story with a small group, and find out what some of the salient, life-directing points that

you may not even be aware of unless you're taken there. That was kind of a self-discovery.

But jumping back into the medical school and the inspiration, I got very turned on in the third year to this question of family medicine, Santa Monica, next door to UCLA, had a good program. Tom Stern was there as a leader, as the director, and I began to get the journals, and I actually became a student member of the AAFP--American Academy of Family Physicians--and started reading about Lynn Carmichael, in Miami, Florida, who had founded the Society of Teachers of Family Medicine; and Gene Farley, in Rochester, New York. I became aware of George Engels' biopsychosocial model which family medicine adopted immediately.

Those became my interests, and I decided to shift my leadership energies over to family medicine, and so I actually turned down the regional trustee offer from SAMA, and became an active student leader with the American Academy of Family Physicians, which I carried very strongly into residency.

Mullan: Where did you pick for residency?

Scherger: I had the opportunity of being in the very first resident class at UCLA, and I was actually on the committee that selected the faculty, but decided I wanted to go somewhere that

really knew what was going on, and where I would have the mentors in family medicine. At that time, the University of Washington in Seattle was recognized as probably the nation's strongest department, along with South Carolina. Those were sort of the two hubs, if you will, of where energy was happening. Maybe Rochester, New York, also.

So I was fortunate to get into Seattle, and so I went up to the University of Washington, which was a mirror image of the UCLA campus, a very large center for health sciences. The School of Public Health was well integrated into the school, which excited me. I learned, as a medical student, that I wanted to get a master's in public health, because I wanted to be more than a well-trained clinician. My primary identity was to become a well-trained clinician, but I wanted to understand the health care system and how it fit in society, and have the background in which I could provide some leadership with respect to health policy and the design of health care.

So I decided not to get an MPH as a medical student, because I thought my skills would atrophy. I decided to do my clinical thing and get well trained as a clinician, and then get my MPH, which is what I did. In the hardworking fashion that I am, instead of taking an extra year at the MPH, I convinced the School of Public Health to let me get an MPH while I was a resident. So I had this integrated program, where I actually finished my three-year residency and got my degree in public

health, and completed my master's thesis, all at the same time. I volunteered at a community clinic again there, and remained very active with the Academy of Family Physicians.

Mullan: Did you like Seattle?

Scherger: Loved Seattle. Great city. My wife hated it. We both loved California, but she could not handle the overcast of Seattle for half the year. I found it an exciting, comfortable place to be, but I didn't have any preference over the Pacific Northwest and California. We had driven around a lot, and we were enamored by Northern California, and so we decided Northern California was the place to settle after residency.

Mullan: The years of residency were which?

Scherger: '75 to '78.

Mullan: And who was department chairman? Was that Ted Phillips?

Scherger: It was Ted Phillips in the beginning, who was a real interesting role model. He decided right at the peak of his career there to step down. He had done his mission there, and

John Geyman came in as the chair, about halfway through my training.

Mullan: And you started to say, you decided to come South again?

Scherger: Yes. I was the University of Washington advocate for the National Health Service Corps. I didn't sign a scholarship contract because I didn't want to lose my freedom, and didn't want to be yanked out of my residency, and they couldn't guarantee me at the time. But I remained very interested, and so I was actually running the booths for the National Health Service Corps, while a resident, and then looked at Corps sites in California. Because I was a volunteer, they showed me the Corps sites that they didn't show the scholarship people.

I already realized I had some interest in teaching. I became a migrant health physician in the town of Dixon, California, with something called the Regional Rural Health Program. We had three clinics. We had our main one in Dixon, that had two migrant camps right outside of town. This is in the central valley near Sacramento. And we had a satellite clinic in the delta of Sacramento, in a place called Walnut Grove, and then another in a little town just at the edge of the coastal mountains called Esparto. It was wonderful.

I, and a guy I'd never met before, David Katz, who did his residency at Rochester, arrived in July of '78, and we were the two Corps docs, and we took what had basically been a daytime free clinic, and turned it into a comprehensive family practice. We took call. We worked with our nurse practitioners at each location. We started delivering babies. We created a very full service family practice operation, with what had been a daytime storefront clinic.

Mullan: This was starting in '78?

Scherger: Yes, in '78. I quickly got very frustrated, though, with the government, and being a government employee in a government clinic. We had twice the budget that we needed. The pragmatist practice management side of me started to come out, and also the awareness of what the feds wanted to measure did not really match the value of what we were doing in the community, and I just found that it was rather inefficient. While it was a very positive experience, it became apparent to me in the second year that I was interested in staying in the community, but not continuing as a federal employee.

Mullan: Did you say they put the twice the funds in?

Scherger: Yeah, the budget of the clinic was something like $400,000 a year, and I knew that was twice as much as it needed to be for getting the job done. So I actually stayed in the town and started a private practice. I started my independent business person side of me, and founded a solo, private practice. I had about ten patients a day follow me from the clinic. I took some of the best staff with me, and set up shop right in Dixon. It's only eight miles from Davis, which is the college town where I lived. A wonderful community. We had had our first son when I was a third-year resident in 1977. Our second son was born in 1979, while I was a Corps doc. We just decided Davis was a great place to have family, raise children. That's where the hospital was. It was very convenient. And so I started a private practice in Dixon.

Mullan: Did the Corps practice stay on?

Scherger: The Corps practice continued. I actually helped them recruit new physicians, and it continues to operate to this day. I started to practice there when we had a very open-door policy, had always taken Medicaid patients and, to some degree, continued to serve the community.

It was funny. There was an old general practitioner in town, even when I was a Corps doc, who gave a lot of diet pills,

and was not what you'd call a role model physician. But it was interesting that when people wanted a second opinion, or wanted a real doc, they went to him, and we were the community clinic doc. So I realized some of the value of being in private practice, as far as status. My Spanish was pretty good.

I also began to teach. I trained a nurse practitioner for UC-Davis while I was a Corps doc, took lots of students, and realized that I could continue to teach in the Department of Family Practice at Davis, which was quite good and very stimulating. So my private practice began in 1980, and then in 1981, Davis hired me part-time, and I started acquiring partners. So my academic career began in 1981, but I never left private practice.

I then began a twelve-year career of having one foot firmly in private practice, doing lots of OB, and building a practice that became seven of us, and occupying a role in both the residency program and then in the medical student programs. I became the director of the pre-doctoral division of our department, as a part-time faculty, and I was in charge of all the off-campus, community-based education. I also was given a job description to make sure that every medical student at Davis that should be a family doctor became one. I became the most popular faculty advisor in the medical school, and doubled the number of students that went into family medicine during the

1980s, which was not a heyday of family practice student interest.

Mullan: What did you get it up to? What percent?

Scherger: We were up in the high twenty percents, and one of the top in the country. Now, Davis had always had good success. In the seventies, it was running that high, but when I took over in '81, it was down to 15 percent of the class, and internal medicine seemed to be winning out, along with all the other specialties, of course, that attracted students. But we quickly took it from 15 back up to 25 percent, sometimes even higher.

I lived an academic life, a private practice life, and a national leadership life, at the same time. When I was a resident, I was the first resident to sit on the board of directors of the Society of Teachers of Family Medicine. I made a strategic decision that I could be a gung-ho Academy of Family Physician activist, or I could get involved in the Society of Teachers of Family Medicine. And I, under the counsel of John Geyman, who really helped me a lot with the decision, shifted over to the Society of Teachers, and that created a domino effect of being on committees, then chairing committees, getting elected to the board of directors, and, ultimately, becoming president of

that organization in 1986, while I was actually in private practice and part-time faculty, which was unusual.

I trace my leadership activities and speaking to 1974, when I was a fill-in speaker for the president of AMSA. It was fortuitous. In L.A., there was a panel to try to inspire practicing family doctors to become teachers, and the president of AMSA at that time, who was from Texas, at the last minute couldn't come. Tom Stern, from Santa Monica, who was in charge of this program, asked me if I would fill in at the last minute, and I did. It's almost like things have never stopped from that speech, in terms of being re-invited. I continue to keep the chronology of my presentations.

The dominant themes in my life have been education, doing education in a way that is non-traditional. My belief is that successful education is when every student gets an "A" because the teacher did the job of getting the information across and inspiring initiative. Education should be fun. It should be exhilarating, albeit hard work. Much of the theme of my career has been career development and education. I got interested in several other clinical areas.

[Begin Tape 1, Side 2]

Mullan: This is Dr. Scherger, tape one, side two, continued.

The additional themes, you were saying?

Scherger: Well, the themes that have really been throughout my career, one is education, which is exhilarating. *Education and Ecstasy*--I forget the author, but it was a key book in college that really set the tone for me. John Gardner set the tone for me in terms of a generalist mentality. His books on self-renewal and excellence were really seminal works for me. And so that theme explains my most recent decision to get back into an education environment. But I always put education and career development simultaneously, not just education for knowledge. I also had an intense interest at Davis, and continue with, of helping people make the right career paths for their own self-fulfillment.

Mullan: Because career development is part of the education theme, or that's a different theme?

Scherger: Right. They're together. A medical school has two purposes: to provide a basic medical education and to help a person choose the right career path after medical school, and I think those are equally important. I think the medical schools do a decent job, depending on their curriculum and philosophy, on providing a basic medical education, and often ignore the career

development. There is an assumption that career choice is a private thing, and students are left to decide in ways that are haphazard and fortuitous.

Mullan: Or non-fortuitous.

Scherger: Or non-fortuitous, depending on the student's experience. So those were my major themes. As a resident, I became very interested in the natural childbirth movement, and actually, my wife is to get a lot of credit. She determined that our first child was going to be born at home, and I was reading *Immaculate Deception* and all the Lamaze works.

I got very interested in natural childbirth. Loved obstetric care and was alarmed by the rising C-section rate, the high-tech way, the indiscriminate use of medications in labor. I actually got very active in that area, which many of my presentations, publications, and work have continued in that sort of activism around birth.

The other area I got interested, also, as a resident, was around death. I remember the cover issue of *The New Physician,* called "Death in Academy," and the way we deal with death in our society. I became very active, did some writing, and began to read in that area. And actually, both of those started, to some degree, in medical school. We started an Elizabeth Kubler-Ross

"Death and Dying" group in medical school, and I took extra obstetric training.

Birth and death, which I looked at as the two punctuating moments of life and very philosophical areas. This continued my philosophy theme, and areas that I just thought modern medicine was fouling up to a great degree. I still believe that one of the great crimes of modern medicine is that we've created purgatory on earth, and we just have a very poor way of winding down and helping bring finality to people's lives.

I think that my obstetric childbirth activism is probably just about over, by my own natural history of my age and my willingness to be available at all hours for childbirth. I feel like I've passed the torch to the next generation, mostly women. I'm just gratified to have had something to do with the education of a lot of the younger activists in childbirth and family medicine.

I see the interest in death and the whole physician-assisted death area, as something that I plan to continue with, and may even end my career, intensely interested in. Those are two clinical themes, birth and death, that have dominated my work. Both more public health and quality of life issues. I was at Davis throughout the 1980s, living a double life of private practice, delivering lots of babies, inspiring medical students to family medicine, being a preceptor. I enjoyed it. It was a ten-year continuity, but I knew that there were some higher

callings for me. I felt like I was in training for something else, a next level of activity.

Mullan: Which you started there in '80?

Scherger: Private practice was '80 to '92. After being president of Society of Teachers in '86, I missed what I learned in my MPH training. I felt like I was getting too locked in to looking at the world of medicine from the family medicine leader perspective.

John Fry, who I had met when I was a resident applicant, traveled a lot with STFM. He was at North Carolina at the time. I first met him in Worcester, Massachusetts, when he was there. He was one of Lynn Carmichael's first graduates in Miami. He went to Worcester, Mass., as a faculty member, then to North Carolina, is now chair at Madison Wisconsin. John Fry was in the fifth class of the Kellogg National Fellowship Program, and told me all about it as a way of really re-opening broad social thinking and leadership skills. In 1988, I became a Kellogg National Fellow. That's a three-year program, 25 percent time commitment. It was a lot of fun and helped my development. My themes of that were: what really makes for quality of life in a community? How important is health care, with respect to other things?

I became intensely aware of how expensive health care is robbing from other social institutions, and probably, as a result, is a detriment to the communities. I trained to be a multidisciplinary leader. It was like three years of public health-type study, and sociology and everything put together, along with a lot of good leadership training. I knew that was job training for a higher level of responsibility. I was the managing partner of a seven-doctor practice. I was a pre-doc director of a Department of Family Practice.

In '91, as I finished that, I was actually extremely excited about the restructuring of American medicine. The fact that we finally were getting rid of what I'd learned twelve years ago, as the cottage industry, and to finally have organized delivery systems in this country. They weren't going to happen as public entities, the sort of single national health program that I was always an advocate for.

I was a card-carrying member of the Physicians for National Health Program, but I became convinced that Alan Enthoven was correct, that the American model was going to based on managed competition. I always felt that it needed to be government-regulated. I think that the government's role is to protect the public and enable private systems to work.

I got very interested in the restructuring of American medicine. I made a strategic decision in 1992, which was a decision that was germinating a couple of years before, that I

wanted to become active in a cutting-edge new delivery system, albeit as an educator, rather than go into academia. So I got recruited to Sharp HealthCare in San Diego, which is a place that my wife and I had always been interested in living in.

Mullan: 1991?

Scherger: Yes. September of '92, I moved to San Diego, after fourteen years living in Davis, and became a vice president for primary care education at Sharp, which put me in a leadership role in a new integrated delivery system, but then also a chance to start the first community hospital family practice residency in San Diego.

Mullan: Tell me a little bit about Sharp.

Scherger: One person in all my reading that I became very interested in was Steve Shortell. Steve started a study group of delivery systems that he felt were going to become regional integrated delivery systems, and as a way to transform voluntary hospitals into truly complete integrated delivery systems. Sutter in Sacramento was one of them, and I'd been chief of staff at Sutter Davis Hospital. I knew the Sutter system, but I felt

like I was way out on the periphery as a practicing family doctor of that system.

I became aware of a sister system, Sharp in San Diego, one of Shortell's nine groups. Terry Kane, a friend of mine who was consulting with Sharp, told me they wanted to start a family practice residency, that they were frustrated by the market to recruit, and thought that growing their own family physicians would make sense. I thought this was a great opportunity to create a new family practice residency, where there wasn't one in any community hospitals. We'd use the new education models of community-based learning that I aspired to, and be part of a cutting-edge delivery system that's not in denial about managed care, and the new population-based thinking for delivering health care. Money drives any corporate structure. It was my introduction to a large corporate structure.

Mullan: Sharp is a not-for-profit?

Scherger: Not-for-profit.

Mullan: Integrated delivery system?

Scherger: Correct. It's six hospitals. They starting acquiring medical groups in 1986, before "PHO" was ever mentioned. They

realized in Diego County, every employer had employees that came from all over the county. If you wanted a health care system that was attractive to employee groups, you had to be located all over the county, and so they began to strategically acquire both hospitals and medical groups throughout the county. They developed a county-wide home health care program, county-wide hospice, had county-wide exclusive contracts with various pharmacies and other vendors. So they literally became a regional delivery system.

Mullan: Starting in 1986?

Scherger: They started this '86, which kind of made them one of the early national models.

Mullan: The physicians that were part of the Sharp system were a medical group? They were totally dedicated to Sharp?

Scherger: Not completely. It was a loose umbrella, and one of the paradoxes is, while Sharp was being a very progressive leader in this transformation, doctors in San Diego are very conservative by nature. It's a conservative, Republican town. Doctors who settled there were usually in the military in World War II. They passed through San Diego, thought this was a nice

place to live, came back after the war, got their medical degree and said, "Let's go back to San Diego. That was paradise. And we'll just set up a private practice and live happily ever after." They are totally unprepared for these changes. And so, consequently, the great tension was the doctors, who thought the sky was falling. Sharp was the messenger that they blamed, and they kind of hated the system.

The only docs that really bought into Sharp were the large, multi-specialty group called the Rees-Steely Clinic. It was a downtown, multi-specialty clinic, Mayo Clinic-type model that formed at the turn of the century. They were acquired by Sharp, eighty doctors at the time. Five years later, they were 300 doctors in nine locations. That was the Sharp model that bought in, but there were nowhere near enough doctors to support all the hospitals Sharp had acquired. So they needed to somehow interface with the private practice community, so they kept setting up IPA network models and just gradually the doctors have come over to realizing that there really is a new structure to the health care system.

Mullan: What sort of insurance product, or products, were they offering?

Scherger: Sharp got its own Knox-Keene licensed HMO, but realized that if they marketed it, the eight or ten major players, which were FHP, Pacific Care, Aetna, Blue Cross, Blue Shield products would say, "We're going to Scripps, Mercy, and all your competition. We'll leave you out." Sharp didn't have the power to do that, so they played ball with all the reasonable health plans, and reserved their own health plan for their own employees, which make up about 10,000. So there are about 10,000 in the Sharp system, which was enough to have a viable self-insured health plan.

Mullan: But they would contract or, in a sense, subcontract with other plans?

Scherger: Right.

Mullan: Just so I understand. You're XYZ employer in San Diego. You contract with Pacific Care, and Pacific Care, then, in turn, would contract with Sharp to actually serve as provider?

Scherger: Right. Pacific Care would offer a menu that would say, "Do you want to go to Scripps? Do you want to go to Sharp? Do you want to go to University? Do you want to go to Mercy? We have contracts with all of them." And they say, "Well, I'll go

to Sharp." Okay. Well, then even if you decided Sharp, you had options to choose from--the network model, called Sharp Community Medical Group, (independent, private docs) or Sharp Rees-Steely, which is a large multi-specialty clinic. So the decision tree went down.

The problem in San Diego is, none of the providers--Sharp, Scripps, University, or Mercy--were strong enough to stare down the insurance companies, and they wouldn't cooperate. The insurance companies were able to squeeze every one of the systems terribly. Every time premiums would get lower, their take would stay the same. They'd pass on less. If Sharp said, "Listen, we can't take this anymore, or we want ten dollars more," they'd say, "Well, Scripps is doing it, Mercy is doing it. We don't need you." So the power was in the hands of the insurance companies until the providers could consolidate enough to be able to stare them down or at least get together, and say, "Look." And, of course, you have the all the anti-trust questions of doing that.

Mullan: Did that happen?

Scherger: It hasn't happened yet. The health plan is still king in San Diego, and the providers are just being squeezed and squeezed, and they're now beginning to lose money. When I came

in '92, Sharp had 20 million a year to re-invest in a 680 million annual company. That is a very small margin--3 percent. The margins had been bigger, but they were designing the budget to have twenty million of "profits."

By '94, it was twenty million in the red. Their reserves were only about sixty million. The company was laying off people and cutting non-essential programs like crazy, but realized that the future was bleak, and the suitor of Columbia/HCR was there, along with some others. Sharp being the first to do things in San Diego County, signed a letter of intent with Columbia.

In my own analysis, I've gotten over the non-profit/for-profit mentality. I think ultimately we're going to have private delivery systems in this country that are going to be held accountable to the public, both by the public voting with their feet, and the protections that I see the government putting over it. I see a future market of regional and national health care companies, with public choice being important. Also, I think the government will have a role, kind of like the FAA regulates the airline industry.

Mullan: But you're saying that the for-profit/not-for-profit distinction is going to be moot, or is becoming moot?

Scherger: I think it's becoming moot. I don't think very many of the not-for-profits will be viable. The only one that I see as viable is Kaiser because of its size and ability, and I know even their situation is shaky right now in their ability to compete. But I think ultimately the investor-owned companies will successfully take over the market, and I think the pace of it will have to do with how quick the industry is able to change. I say that because the Attorney General just blocked the Sharp-Columbia merger last week by saying that Sharp was undervalued, that the foundation was not going to be adequate. Sharp turned down better offers from other companies which was testimony to the undervaluing Columbia did, and so the whole thing has been halted. But I think ultimately that's likely to happen.

Mullan: You mean that that probably will go through?

Scherger: It'll have to go through, because I think the non-profits will not have the capital to go through what I call the window of hell. The window of hell--I wrote an essay on that--is a time when your whole structure is designed for one economics, which are fee-for-service, and all of a sudden, the economics switch to capitation, or fixed budget. You cannot restructure yourself enough to stay pace with the change, and so you go through a period of time when your costs, your overhead, which

was designed for success in fee-for-service, lots of technology, lots of specialists doing things, will lag, and then you go through the horrible time until you're redesigned for efficiency.

General Motors went through a window of hell when they realized their cars were not what Americans were buying, and they had to somehow catch up to the Japanese. They had to go through this period of time to re-engineer their company and finally emerge as again a viable, successful company. I see many of our health care systems, whether they be independent hospitals, or even the new delivery systems, being out of pace with the reality of the market.

Mullan: I do want to talk more about managed care as a whole, but let's pause for a moment on the rather unique role that you played, or opportunity that you had, to design and implement a teaching program within a managed care structure.

Now, just again, for my own clarification. Sharp occupied a sort of hybrid, as I understand it, position, being in part a provider, both hospital and physician, and, in part, a risk holder, in the sense of having a 10,000-person plan that was their own. But for the most part, it was more like a hospital bricks-and-mortar operation, with certain physician groups organized around it.

Scherger: Right. Yet the provider--Sharp needed to take care of seven or eight hundred thousand people to support its debts and overhead. I call this the hardware. So, yes, it was really a large umbrella provider. Its own health plan was priced in a way that it did fine. It didn't get hurt that way at all, and it was well managed.

But Sharp's real problem was the size of the operation. It acquired community hospitals, some of which were even district hospitals, with district boards, who were wedded to the future of success of those hospitals, and making sure that all of their programs, including cardiac programs, etc., survived. It's kind of like a family trying to downsize by selling off some of its children, or selling off part of its own houses and things that all have people invested in. Sharp struggled in doing that, and realized that it needed an outside force to come in and do the hard work of downsizing.

Mullan: Which is the HCA?

Scherger: Exactly.

Mullan: But in terms of their establishing a residency program, they have more in common, in terms of their structure, with say, UCSD, than they do with Healthnet or Pacific Care.

Scherger: Absolutely.

Mullan: As an organization.

Scherger: Eighty percent of family practice residencies are not at medical school hospitals. They're not at academic teaching centers. They are in community hospitals. Some of them are public hospitals, like the small county hospital that San Bernardino and Ventura have, and some of them are in a Kaiser or Group Health Cooperative, who have always been in managed. But most of them are in private hospitals, usually are non-profit, such as Long Beach Memorial and Santa Monica Medical Center.

I modeled the Sharp residency program after Fairfax, Virginia. One of the great pioneers of family medicine education was Fitzhugh Mayo in Virginia, and he said in the early seventies, "I'm going to build residencies off of community practices, not off the hospitals." The community practice was going to run the residency, contract with the hospital for all the necessary in-patient training. That model was really revolutionary then, but one that fits the nineties perfectly.

At Sharp, because the whole system was the organization, I wasn't wedded to the hospital. We built a three-office faculty practice very similar to Fairfax Family Physicians, and basically ran the residency out of that, with rotations in the hospitals.

But the hospital didn't own the residency, even though the money passed through.

Mullan: How was the money generated? Where was the money coming from? How much money was necessary?

Scherger: We borrowed $2 million, most of which was to refurbish and create office space that was adequate for the faculty group and the residents. But from the very beginning, we were based on a model of a large group of clinician teachers, rather than an only-as-big-as-necessary group of teacher/clinicians. And so I actually started a faculty group practice before the residents ever arrived in July of 1994. I had sixteen doctors in three offices who were practicing, getting ready to teach.

Fairfax at the time was thirty-five physicians and eighteen residents, with most of the physicians spending either none or a half-day a week in education. There was a core of five or six faculty who spent more time teaching and running the residency. And that's what we did at Sharp. I wanted real-world practices that were very substantial in size, strategically located in three parts of the county. The residents learned within that structure. Only 20 percent of the patient care done by our program was done by residents in the office. Eighty percent was being done by faculty.

Mullan: So the residents were sprinkled, then, amidst an active practice group?

Scherger: Yes. They had a core practice. They were not scattered, because family practice doesn't allow that, so they had a nurses' station that was theirs, they had offices that were theirs. They had a wing in of one of our practices that was really their hub, and they did see a somewhat different patient population. They had much higher Medicaid than we did. They collected their patients out of their hospital rotations. But it was all one practice--faculty and residents. We took call together. There was no separation of function between the faculty practice and the residence practice.

Mullan: Very interesting. In this day and age, there's the question of who's going to support what. What was your experience with the cash flow in this whole operation? Who was paying, who was getting paid, and what is the environment like for replicating this, or not?

Scherger: The residency pays for itself, with the help of the federal dollars. I believe that the residency has the potential of paying for itself, even without the federal dollars, but that would be a big stretch.

Mullan: The federal dollars being Medicare?

Scherger: Yes, the Medicare GME dollars. Fortunately, at Sharp we had someone who had experience in relating with Medicare, and so we were well prepared to get the direct and indirect reimbursement. When you start a brand-new program, the money comes in higher than expected in the beginning, because your ratio of residents to beds. We only had ten residents in '94. We ended up getting over $100,000 per resident when the money finally came in. But we look at the federal money as paying the resident salary and benefits and some of the teaching time that's based in the hospital. But in the office, the residents pay for themselves. They don't have to pay their own salary, but what they pay for the preceptor. A preceptor can supervise the care of as many patients as he or she could ever see themselves, actually more. So let's say a faculty would see twelve patients at half a day. Well, if that faculty supervises twelve patients seen by a resident, the productivity is the same, and the overhead is roughly the same. So our in-office supervising time is paid for by the clinical work of the residents.

Mullan: Break even, break even plus?

Scherger: It was actually a break even plus, and it covered the faculty fairly well. Not much plus, maybe 10 percent, because the overhead is higher when residents are seeing patients. You've got to have more nurses, more exam rooms, and equipment. They're not very efficient. So the clinic is very much of a break even. Ultimately, it was a little bit in-the-black operation.

The hospital side was happy because the Medicare dollars and we started saving the hospital money. They didn't have to buy the ER coverage in primary care that they were buying before we arrived. We did it. We were admitting an average of twenty-five to thirty patients a day in the hospital, and so we were a major provider.

They had struggled to get doctors to cover the low-income patients. There was a debate--how many new patients did we bring into the hospital? Probably some. But what we really did is provide a ready, constant source of care for all the people who stumbled into a very busy ER that needed to be admitted, in which they were struggling to find private docs to do. We now admitted the bulk of those people.

It was very interesting. We actually tracked where we made a major impact on the community, because the number of people who came into the ER without a doctor was cut in half when the program was eighteen months old, because they were now providing

continuity to these patients in our resident clinics. You'd have So-and-so show up, and no longer are they a person that nobody wants. They're now resident So-and-so's patient.

The goal of the residency was sophistication in what family doctors do, and so we really pushed the office practice. Our residents spent twenty weeks of their first year in a fairly traditional house staff/in-patient role, sixteen weeks on internal medicine in our hospital, and four weeks at the Children's Hospital, and the rest was very much in the community, learning in blocks, with two half-days instead of one in our family medical center. And then we really built on that community and office practice in the second and third year.

My goal was that no more than 40 percent of the residents' experience would be in-patient, and we accomplished that fairly well, so it was a very progressive program that way. And, fortunately, the Residency Review Committee for family practice has become flexible enough to allow for that. The hospital didn't care as long as some basic needs were met. They really didn't care that our residents were doing all their urology and surgery out of doctors' offices, rather than in the hospital.

Mullan: Did Sharp have other residencies, or just family practice?

Scherger: Only family practice.

Mullan: This is a digression, and we shouldn't go very far into it, but based on your experience, what do you think about the viability of other residencies based out of a similar organization?

Scherger: Very good. There have been eighty new family practice residencies since 1990. Integrated delivery systems are realizing that as they design themselves to take care of the population, a residency program, it brings in real quality family docs to be faculty. At Sharp primary care was the weakest link in its system. It had great specialists, transplant programs, great hospitals, but when it looked around to the primary care, it was weak. In the 1980s, many of the family practice graduates went to work for Kaiser and other large groups. They didn't go into independent private practice. And so the residency was a way of jump-starting quality and presence in primary care.

Mullan: And providing some glue to the specialists.

Scherger: We became the fastest-growing practice in the whole system, for new lives, and the faculty, with their reputations, would generate the lives. They were very clinically based. So,

it's a very, very viable model. The federal dollars, to be able to provide, as you said, about $55,000 per resident, per year, into that, really makes it very viable.

Now, it's not lucrative. Northeast Ohio did an elegant study of six programs, of which five of them were in the black, only by a small amount, and that was based on a fee-for-service model. It still works on a capitated model if your residency program can be one of the players, and recognized as one of the players in the system.

Mullan: What is happening with Sharp now? What's happening with the residents at Sharp? The sale, is it in jeopardy?

Scherger: No. Sharp has cut its costs so much that it'll hang in there. Sharp is now stable. I call it the limbo period. There's no growth, there's no strategic planning. When I came in '92, it was an exciting time. We were talking about future care models. There was a whole quality team running around that had been CQI-trained, and you had all this good, value-added, exciting stuff going on to make Sharp a premier delivery system.

All of a sudden the money was gone. Anyone who's not at the bedside was in jeopardy. All these nurses, who had worked their way into briefcase jobs" were being eliminated. The ward nurses call them "scarf nurses," the nurses who wear scarves to work,

instead of their uniform. They were all, all of a sudden, laid off. We had two summers where 300 administrators were laid off, and then all of a sudden, all the value-added things were just disappearing, and everything just got down to the basic patient care. Hopefully, the clinical reputations of the doctors in the hospital would be enough to carry the reputation of the system.

I saw flat growth, just a period of consolidation. The residency was a bright spot, because we were growing. We had twenty-six residents when I left, and seventeen of them were women. There weren't a lot of women primary care doctors around. They were a very refreshing addition, committed to OB. And so in a system that's kind of just holding its own and not doing anything interesting and exciting, just trying to keep itself together, the program was a positive--

Mullan: But you decided to move. Why? And what's the new job?

Scherger: Department chair offers were coming my way for the last six or eight years, and I even looked at a couple. But I decided that the role I had at Sharp was really good. However, I learned that when things got really tight at Sharp, education was expendable. My residency was on the hit list every time they said, "We have to reevaluate everything we're doing," then I had

to say, "Well, look. The residency is no longer a cost center. Save it. Save it. Save it."

But I realized, when push came to shove, education is not part of the foundation at Sharp Health Care. It's clinical delivery, period. So I felt rather vulnerable. I also felt like it's a great program, it's very interesting, but I wasn't going to go anywhere more with it. Also, though, didn't see that being one of twenty-five or so competing department chairs in the medical school was any better, and so I wasn't interested in that portion.

UC Irvine said, "Our school needs to be re-engineered. We're not going to survive the way we are. We can no longer pretend to be a UCLA or UC-San Francisco. We need to be defined as, at least in a major part, a primary care-oriented medical school. We've got a community mission of relating to the communities of Orange County and the surrounding area. We want your leadership to make us a premier, community-based, primary care oriented medical school."

I said, "If you could put me in the central leadership of the school, I'd be interested."

So I'm in an associate dean position. The dean's office is over both the health system and the school. I consider myself just a mission-driven person. If there's a mission worth doing, and it's important, and I think I could be good at it, I'm driven toward it.

The real ulterior mission here is that the University of California has never been community-oriented in any of its medical schools. It's been very traditional, research excellence, world-renowned, but not really in tune with what's going on in the state of California. All the other good stuff is fine, but I think any state-supported, public-supported school has an inherent mission to be very attentive to the needs of the community.

I think now, with the changing marketplace, the University of California is going to need to start to begin to think that way. It's very exciting to me to be a key player in the University of California, not just Irvine. Irvine is a leading example, but the whole UC system to begin to think about community responsiveness.

The Isenberg legislation that was put together to demand the right workforce balance coming out of the UC system, downsizing specialty physicians, demanding that there be an increase in primary care, was passed. The governor vetoed it, but turned around to UC and said, "Do it, but I don't want to have a legal stick that forces you to do it. I believe in academic freedom, but you'd better do it, or we'll have to re-visit this issue." It's exciting to me to be part of this process. The university is out of denial. In '92, the medical schools were in denial about the changes in health care

Mullan: This school, or all schools?

Scherger: Well, all of them to various degrees. I don't know many med schools weren't in denial of managed care and the new delivery systems in '92. Now they're looking for leadership, and I think this is a leadership opportunity to work with the changes to make the school really community-responsive. So it's getting back to the community medicine effort in a new context.

Mullan: A quick final word on primary care, family medicine, in the broader movement. Where do you see it headed?

Scherger: I see that the generalist physician, the physician who is committed to the whole person, family and community, is going to have a sustained period of renewal and focus. I think the ideals of community-oriented primary care, the old COPC movement, will all of a sudden become relevant and actualized for the first time.

Primary care needs to work together. There's a culture of people that go into internal medicine that are generalists, a culture that go into pediatrics, and family practice. They need to become brothers and work together in a tripartite way, maybe even with a new breed of OB/GYNs that are really devoted to whole woman health care. Together they can balance our physician

workforce in the country and address the real health care issues that are out there.

So I think this new reformulated structure, of health care in the U.S. will have the clout and economics of corporatization. New immature delivery systems are money-oriented and there are robber barons and carpetbaggers out there during this time of crisis and change. But ultimately I see us ending up with much better balanced delivery systems that are addressing more than the past, the health care needs of the communities. Integrated primary care specialties can lead the way.

Mullan: Let's go to the next tape.

[Begin Tape 2, Side 1]

Mullan: This is tape two, side one, Dr. Scherger.

We're talking about primary care futures. Two elements of the landscape that arguably offer threats to the more Pollyanna view of primary care physician futures, one is the growing presence and effectiveness of nurse practitioners and PAs--and I don't mean that in a threat way so much as there is another element to this that has sort of been a fairly robust growth phase, and I'm curious as to your vision about intersection between physician and non-physician primary care.

Secondly, something I've learned about only since coming to California this time, the primary care bypass products that are beginning to appear on the market trading or trafficking in the perception of some patients that they are getting inadequate specialty access, and they're trying to sell ways around the generalist. What do you think about both of those phenomena?

Scherger: I've been a big advocate for nurse practitioners and PAs since I was a medical student, working with the program in Davis. I've trained many. At Sharp, we ran a program for PAs. I'm a firm believer in collaborative practice causing efficiency. I think a family physician can do a better job taking care of a population of patients with a nurse practitioner or PA working alongside. And there are different models of ratio of doctors to mid-level providers.

I have no fear of mid-level providers replacing doctors. I think that the background and nature of training gives them some primary care skills, but the ultimate doctor-patient relationship, and the responsibility, will be sustained. I think it'll dampen the need, in terms of sheer numbers of primary care physicians, but the specialties of primary care, if you will, will remain robust.

I envision some delivery systems investing heavily in nurse practitioners and PAs, and then the competing delivery systems

having billboards saying, "We guarantee you're a doctor." Kaiser has learned that lesson. Kaiser has waxed and waned in its nurse practitioners and PAs, and has laid off many nurse practitioners and PAs through the years, realizing that it needed to offer physicians in order to stay competitive, and I don't see a change in that. I don't see them as replacement providers.

The other issue is a very interesting phenomenon. I've become more and more aware of the American value of choice. It's only in the last year or two that I've realized how important freedom of choice is to Americans, and the whole gatekeeper model, the primary care mandate of managed care, violates the American ethic of choice. And Americans love to have choice, even if they're not going to exercise it.

It's interesting, this Access Plus HMO of Blue Shield. It's very popular and is the new wave. Everyone still has to pick a primary care physician, but if they're willing to pay, say, a $50 co-payment, they can go see a neurologist for their headaches directly. I don't mind the primary care physician not being a requirement. Being a requirement instead of being an elective really changes the dynamic to a great degree. It's a lot more pleasant to see people because they've chosen to see you, rather than if they have to see you. It'll get rid of these relationships where people will come in just demanding their referral to a specialist directly.

So I'm all for preserving choice, as long as it's tied to some economic responsibility, and that's what these new plans are doing. Sure, it's choice, but choice for a price. You'll have to, in a sense, pay for it if you want to take "this other option." In truth, the California Academy of Family Physicians has had a lot of dialogue with Blue Shield mostly over the marketing language. The number of people that are actually choosing to go directly to specialists is very small. Knowing that you have that choice is comforting to lots of people.

There's a gimmick involved with it, to some degree. Because of the inherent efficiency of having a primary care provider who can handle 85 to 90 percent of the health care needs you enter the system with, that efficiency is so great that the cost of fragmenting is so inefficient that ultimately it's kind of like the airline. You'll fly Southwest for a cheaper price, and you don't really care that they don't offer anything more than bags of peanuts and a drink. Their on-time service is good, they get you there safely, and they're convenient, and you're sure glad that you're not spending an extra hundred dollars for your ticket.

Mullan: Well-stated and interesting. Your sense of the future. We talked a little bit about primary care future. Managed care

future and the sustainability of teaching in this environment that's downsizing and squeezing?

Scherger: Well, we need to deal with funding a medical education. Medical education is not going to be taken care of in this new market. This new market will be operating on small margins delivering, hopefully, quality care at an affordable price. Education is not part of it. It's got to be built into it. So we absolutely have a need for a new structure that pays for medical education. An all-payer tax, an all health plan payer tax would be a marvelous way.

I only hope that our legislators, along with the public, realize that it's good policy to create this. We create an extra fifty-cent tax, whether it be sales tax or whatever, for good-gesture kinds of things. One of them is someday going to have to be medical education. So that's just needed, and meanwhile, we're just kind of holding our own and dealing with a system that has perverse incentives through Medicare, until that time comes. So that's got to happen. I believe and hope, hope and believe, that it will.

I'm an optimist, as you can tell. A bright vision of the future, that's what drives me to work toward it. My biggest fear in the future market is that, like the airline industry, my good buddy Rich Roberts made the comment: "I don't know a lot of the

airline employees that are all that happy these days." The stress of running an American Airlines or United Airlines in a day of continued price wars, need for new technology, major safety issues, terrorist issues, if you will.

We demand quality at the lowest price so much in this country that we put an enormous stress on our providers, whether it be shopping centers, both in manufacturing and in our service industries. We may end up with high quality at the lowest price, with a lot of people with ulcers and stress and whatever, and churning people up. I think the fact that the market never guarantees health and happiness, we have to figure out ways of injecting health and happiness into a market.

I'm fascinated by the Southwest Airline example, because it's the lowest price airline. It's the number one in consumer satisfaction. It's always running on time, and it has the happiest employees. There's a lot of flexibility in dress, they're allowed to tell jokes on the plane over the mike system. They have certain discretion but they have a genius for creating a fun working environment for their people.

What I see is that we'll have periods in which health care companies will be, in the name of efficiency but also rigidity, become, if you will, terrible places to work and maybe quality will suffer, but then a new one will come along.

One of my residents at Sharp, her husband is a software computer designer. I was talking to him. He would never work

for Microsoft, because he says it's a horrible place to work. It sounded like working for IBM during the worst time of pressure without reward and whatever. But he said, "I work for First Virtual, which is a new company, very exciting."

I think that in health care, we'll have to have these periodic renewals of companies that have a better way of doing it, in a way that draws people both to work for it and to receive their care by it. That raises questions of continuity of care. You've got to get away from people switching doctors every two or three years. Terribly inefficient. You do have to have some stability and some sustainability in the market. Hopefully, there can be some consistency of provider with patient, even though the health plan may change every few years, and somehow that structure is going to need to happen. So, huge questions are out there.

Mullan: There are a lot of questions, I think.

Scherger: The trouble is, the beauty of things in this country, if things aren't working, somebody comes up with something to make it work better. You know, Federal Express, to give an example. So I see it as a pretty exciting future, with a lot of change and restructuring and difficult periods.

Mullan: What about family? You talked a bit about your wife and two--

Scherger: Two sons.

Mullan: As your career has progressed, and they have progressed, how has that all interacted, and how do things stand now?

Scherger: Well, I have one son in college, first year of college. He went back to Davis, what he considers his home town. He's very happy there. My other son's a junior in high school. We're very blessed that they're both ambitious, and I'm not worried about either one of them, although we have no idea what they're going to choose to do. Neither of them talk medicine, but I wouldn't be surprised if they find their way into it kind of like I did, as a self-discovery in college or later.

I look at continued leadership on whatever level I'm privileged to do so. I've got to face a decision of whether to run for the presidency of American Academy of Family Physicians in about a year and a half. I look forward to opportunities. I enjoy being on the Clinton-Gore health policy team, and some of those conference calls that came from that. I consider Al Gore probably the greatest statesman in Washington. I'm very excited about his environmental consciousness, for example. I thought

his book was very profound--*Earth in the Balance*. If I had an opportunity to be part of health care leadership in an administration like that, I'd be interested.

I've enjoyed being a person who's had a lot of privilege in terms of things I've done. I'm not in it for me and what position I have. I'm really in it for opportunities to contribute to missions that I care about a lot, which the themes of good community medicine and health care for the public, quality-of-life issues, getting back to those "save the world" things.

Mullan: What is your wife doing now?

Scherger: She's at home. She's not a career person.

Mullan: Like her respiratory therapy. Did she get her nursing degree?

Scherger: Yes. She worked as a nurse during my residency. When she became a mother, she became a mother full time. I travel a lot, I'm very active. Her counterbalance has been to be very stable at home and focus on the day-to-day needs of the kids, and the home. I think that as the kids get launched, she'll be biding her time until she's a grandmother. She enjoys travelling

with me, but she doesn't want to even be in a role that would--compete might not be the right word--but we really are a couple that works because we're opposites in our drive and ambition.

Mullan: Anything we haven't touched on that you're anxious to get on tape?

Scherger: No, I don't think so.

Mullan: We've covered a lot of ground. Thank you.

[End of Interview]