Kendal Williams, MD (Host): Welcome, everyone, to the Penn Primary Care Podcast. I'm your host, Dr. Kendal Williams. So, we started this podcast in order to support primary care physicians, both within the Penn environment but also outside of Penn, really, with practical clinical guidance, advice, based on the experts we have here at Penn and how they can inform our practice patterns and our practice strategies and really just help us solve problems.

We've done a couple of non-clinical topics, but today we actually want to do something much broader, because this podcast has really been about promoting primary care. So, what we want to do today is talk about what it's like to be a primary care physician. We are actively recruiting people out of residency programs to stay in primary care.

We're going to explicitly say that. Penn is hiring and we're actively recruiting people to work for Penn. But we're also actively recruiting people into the profession, into the field. And so, for today, what we wanted to do is have a discussion about what's great about primary care and then what are some of the challenges, and also clear out maybe some of the misconceptions about what it's like to be a primary care physician, but also where the field is headed.

So, to do that I invited back an old friend of the program, Dr. Joseph Teel. Dr. Teel is faculty in the Department of Family Medicine and Community Health at Penn. Last time he was on, he had a significant role, but now he is the Chief of the Regional Primary Care Network for Penn Medicine.

Joe, thanks for coming again.

Joseph Teel, MD: Yeah, it's great, Kendal.

Host: I'm also thrilled to have on Dr. Ada Emuwa. Dr. Emuwa is a Family Medicine Physician in the Penn System. She works out at Penn Medicine Lancaster General Health. Ada, thanks for coming on.

Ada Emuwa, MD: Thank you for having me.

Host: So, we're going to start with what's great about primary care, and why we're doing this. I went to medical school at Penn and then I trained at the University of Pittsburgh, and one of the things that happened to me when I went out to Pittsburgh is that Pittsburgh is a wonderful general medicine training program, so I was exposed to these wonderful general medicine physicians who really became my mentors and I learned about how interesting and diverse and challenging primary care could be through that community and then was able to

come back to Penn and be part of the Penn community. So, I'm a big advocate of primary care. I think it really is an extremely challenging and rewarding field.

But I want to before I start to sound like a cheerleader, I actually want to ask, Dr. Teel, Joe, what brought you into this field? What do you enjoy about it? What do you think are some of its benefits?

Joseph Teel, MD: Yeah, so Kendal, my path was maybe a little different than some others because I actually entered medical school somewhat knowing I would be going into some sort of primary care or primary care adjacent field. I was part of a program called the National Health Service Corps, and so was lucky enough to be accepted into that program senior year of college and had the benefit of being here at Penn Medicine as well for medical school, but was on the National Service Corps role at that point. And so, I knew I was going to be doing some sort of primary care field, but through my training here I realized that that for me was going to be Family Medicine, and I think like many other family docs, I realized I kind of liked doing a little of everything. I love I love seeing kids and adults and delivering babies and doing procedures in the office and so, ended up choosing family medicine for residency training and obviously continue to practice clinically today.

And so, for me, it's been a long focus on primary care. That luckily it worked out perfectly for me and I've been very lucky to have a very fulfilling career thus far.

Host: When you were a youth thinking about this, was it the idea that you would be serving the community, the public health aspect? What are some of the things that really attracted you?

Joseph Teel, MD: Yeah, I can actually remember being in my interview for the National Service Corps scholarship and there was this question, sort of like, tell us about your engagement in the community or like your thoughts on community health. And I will still vividly remember reflecting on my grandfather who was our postman.

And the, not necessarily impact, I mean, you know, you could say he, quote, just delivered mail, but the ability for him to make connections in our community and, to be known as sort of the postman for like 40 years, I think it instilled in me this idea of connection to the community and that sort of being a part of your community is, somehow integral into our day-to-day lives.

And so, I still think back to those days and of why I chose to go into primary care field and then, even today live in the community that I work in and try to serve.

Host: I grew up in a small town in Pennsylvania, 2,000 people and the physicians I knew did everything and they were part of the community and everybody knew them and everybody went to see them and so it was that community thing, aspect that was deeply attractive to me. I also didn't, I enjoyed everything in medical school.

I did a neurology rotation, thought I wanted to be a neurologist. I did trauma surgery, I loved it. I think if I had not done Gen Med. I would have been a trauma surgeon. But I found that I liked everything so much that the best way to fulfill all those needs was to do general medicine. How about you, Ada?

How did you get into this field?

Ada Emuwa, MD: Well, it appears as though my journey may mirror a little bit of both of yours. I actually remember at a very young age, I wanted to get into a field where I could help people. And I was born in the United States and moved back with my family to Nigeria. Even though we lived in the suburbs at that time, my parents made the effort to have us visit our villages back home where they grew up before they left to gain their education.

And I remember being really impacted by the fact that there were people there who got sick and died of diseases that were really preventable just simply because they didn't have the education or the resources to be able to take care of themselves. And so I, going into medicine became natural in a sense because I loved biology.

I was thinking about law, but when my mother told me that I'll have to defend people who are guilty, that quickly made me change my mind. And so, fast forward to coming back to the United States, completing my education, and I just initially was interested in pediatrics, because I loved working with children. And I started to realize I was really interested in preventative care because I really thought that was a big focus in terms of preventing people from getting sick in the first place.

And eventually during medical school, I realized I loved all facets of medicine, all people. And with my interest in preventative medicine, I realized really quickly that I also liked public health. And that allowed me to get trained in public health. I got my master's during medical school, actually.

And eventually, I'm really fortunate to, as a family physician, have the opportunity to practice seeing adults and children as well. And I did also a National Health Service Corps. With that, my interest in underserved medicine became evident. I worked in federal qualified health centers for many years. Currently I'm with Lancaster General Health in a location that also is in a city that has a high proportion of people with diverse backgrounds.

I currently, I'm the co-chair of our DEI, Diversity, Equity, and Inclusion Council because I have that continued interest in trying to make sure that people have access to health care and are treated fairly regardless of their background. And so that's what keeps me passionate about primary care.

Host: So, you know, as you were expressing, I was thinking to myself, you know, that the first line of, defense for health and disease is the public health work that is done; clean water, vaccinations that are distributed in the community and so forth. And then you get up from that and there we are, right? We're the ones that are individualizing all of that knowledge to specific patients, right?

Ada Emuwa, MD: Exactly.

Host: You know, so I think let's just talk about clinically and I'll just throw some things out about what attracted me from a clinical perspective. So, first, as many of you know, and I've said on this podcast, I practiced hospitalist medicine for about 15 years. And that has great advantages that we can talk about later and how that compares to primary care.

But the thing I missed was the patient continuity. I also felt that I was often seeing diseases where the horse was already out of the barn. Most hospitalizations in this country are folks that are chronically ill. And their hospitalizations are often the result of either long years of sort of poorly treated illnesses or the lack of really continuity of care in the community, outside of the hospital.

And I found more and more what I was most interested in in a hospital-based environment is how we could get people back into good primary care, because that was the bedrock. That was the foundation. That's where real work could be done in keeping people healthy. And so, you know, it was really that idea of continuity and also the idea of the fact that as a primary care physician, you're really connected to everyone in the care environment.

I mean, you are the sort of quarterback, if you will, of the team and people rely on you in that way.

Joseph Teel, MD: Yeah, I mean, Kendal, I can jump in. I mean, certainly now I've been lucky enough to be at Penn for the past 14 years. And so have been able to establish those longitudinal relationships with many of my patients, the family units that I care for. And I think on both ends of the sort of age spectrum, it's been really amazing to think back to the kids I delivered 14-years-ago who are getting into adolescence, into high school and as well as the older individuals who have aged and many of whom have passed at this point and I've helped they and their families perhaps deal with the loss of a loved one or the end of life issues that come up as we think about that portion of our lives.

And so certainly, that idea of these longitudinal relationships, caring for family units or groups of individuals and understanding their social context. Ada mentioned the idea of thinking about our the social needs of our individuals and the work she's done in federally qualified health centers.

I think all of that understanding, I think you're right, is the bedrock to, you know, what we do day to day.

Ada Emuwa, MD: I definitely agree with that perspective and even taking it a step further as well, looking at what we do as you said, the bedrock. The fragmentation of healthcare really currently is unfortunate, because if one thinks of the way things used to be, the primary care provider being the base, right, and I tell people, as your primary care provider, I'm kind of like your center.

I'm there all the time to ensure things are stable and specialists are there for us to consult. But at the end of the day, your primary care provider is your home. And that's why we call your primary care home. And I feel like really more needs to be done to kind of bring that picture back, whether it's from the emergency room with specialists, you know, stating to them, do you have a home? Do you have a primary care provider? That's what they're there for. Having someone who can coordinate all your care in one place. And, really, I think that really will tie into the purpose primary care also, which comes to prevention, because if you have people only going to their specialists when they need something or having specialists manage things just on the periphery, it really doesn't get to the sense of the whole person.

So, really, with your comments, it really just kind of hones in to the reality we really need to bring the concept of primary care and the purpose of that back to the reality of how medicine is practiced or how healthcare is practiced here in

the United States now, just in terms of highlighting the importance of primary care.

Host: I agree, and I think a lot of graduates of medical schools want that kind of experience, want that focus. I even get subspecialty notes back from cardiologists and others, and they're doing primary care, you know, and some of them are sort of quasi primary care physicians, and I think to myself, you really should have just done primary care, you could have done most of what you do now.

So, let's, talk about, you know, you're a graduate coming out of residency and maybe you haven't necessarily had the background that you had where you kind of know that you wanted to go into primary care. You're more undifferentiated, similar to what I was, I think. And you're looking at a field that will have those rewarding features, but then it's often, I think the practical stuff that gets tripped, that trips people up.

The pay, right, so primary care pay has historically been lower than other specialties. And the idea that you really are taking on so much, you know, you're taking on the care of maybe 1,500 to 1,800 patients and all of their concerns and managing all of that. And, that requires some out of, out of office work in order to sort of be responsive in that way.

So, Joe, you're, I know, involved in recruiting for a residency program in family medicine and folks that are thinking about going into primary care and then you're also helping to place people in primary care jobs once they finish a, a residency program. How, what are your thoughts on the pay issue and sort of the idea of just being sort of overworked and overchallenged?

Joseph Teel, MD: Yeah, I mean, certainly on the pay issue, you know, it's going to be a while, if ever, that we're going to make the same amount of money as a neurosurgeon. We got a big gap to close there, but I think certainly even at the national level, I think we're seeing a small shift in even CMSs way that they are going to start reimbursing medical services in this country.

And so, I think we're acknowledging that number one, there probably needs to be more incentivization within primary care from a financial perspective in order to get the medical student who is thinking about it, not disincentivized because they're not going to make as much money as their colleague who's graduating at the same time in a few years.

And so little things like the fact that the reimbursement, CMS reimbursement, has gone down this coming year or is proposed to go down, which is not a great thing, obviously, for health systems or in the medical community in general. But then, CMS activated this G2211 code to give individuals or clinicians who have longitudinal relationships with their patients and longitudinal care some additional benefit or additional financial incentive to maintain those longitudinal relationships and longitudinal care.

And so even though it was a small shift, I think we will see actually our, the clinicians across our system and all the systems in the country, if they're, providing longitudinal relationships and care for chronic disease, you will see a bump in your pay if you're, you know, using that code. And so, I think CMS acknowledged they didn't want to, they basically wanted to try to shave some dollars, but not do it from primary care.

So, I think that's a small example. And then also you can look at models of shared savings within ACO models and other shared savings models where primary care, in many instances, becomes a significant beneficiary of those dollars when we're able to actually save money and reduce costs for our health systems and patients.

And so, I think we're heading in the right direction. We've got a lot of ground to cover but I think we, I think the system and the country has acknowledged that, you know, we can't continue down the same path we've continued for this many years. The second question around kind of the, what it looks like in terms of the burnout and just the stress that comes with this job.

I think I'm optimistic that I, we've hit I would say maybe a nadir or sort of the low point of our work. If you want to use the term work life balance or however you want to phrase that the amount of work we're doing after hours from an, you know, in-basket effort perspective and all the additional things you mentioned, Kendal, in terms of like that stuff that keeps us working at seven o'clock or eight o'clock at night.

I think the country, not with even within primary care, but within the field of medicine, I think has acknowledged that it's not sustainable. We have people quitting, leaving the field and also hesitant to enter the field because of what they hear. And so, I think we as a health system and many others, but I think, we're all taking a much more active role in this.

And so even within Penn Medicine, you're seeing, many more efforts to try to reduce in-basket effort, support documentation to make writing our notes easier

with the use of AI and other ambient listening technologies. We're getting additional support from enhanced care team members such as our NP and PA colleagues.

We're all working I think much more collaboratively to try to solve for these problems. And I am very hopeful that our lives, I think that pendulum is going to swing back a little bit towards a more sustainable model of care for the primary care clinicians, within our system and beyond.

Host: Ada, what are your experiences with that aspect? I mean, both the pay issue and the work life balance issue?

Ada Emuwa, MD: I think in regards to the pay issue, it's a reality. People know going into primary care that your income is not going to be the same as a surgeon, as was said previously. I feel one strong aspect really should be financial education, should really start much sooner in medical school. I feel that if you go into life with less debt, especially in primary care, you feel more comfortable moving forward.

I saw a lot of colleagues who made poor financial decisions, even in medical school, what kind of cars they bought, et cetera. Choices in terms of loans, you know, how to apply for scholarships, how to just save. And I feel it's unfortunate, especially because people feel they're going into quote unquote, even though they're not going to be a surgeon, like some of their colleagues, they're still going to be higher paid than other friends they went to school with a college with. So, people go in spending and feel like, oh, you know, I'm going to pay down the road. So, I feel like financial management. I know some institutions are starting to do that sooner rather than later, but I really feel that starting that concept much earlier in medical school education would be helpful, so that people, as their lives unfold, feel comfortable as a primary care provider throughout their lives, instead of feeling like they have to, they're always in debt, they're, et cetera.

So, that's one thing that I'd really like to see. And I feel like, you know, even for people listening in, no matter what stage you are in your education, start asking yourself, if I'm not getting that from my institution, how can I just take a step back and start to save or have a better cushion in terms of my loans?

You can even start in undergrad, even, for people who know that they're pre med. That said, programs such as the National Health Service Corps were really helpful because, yes, they did hone in on if you're interested in primary care, we

can help you with your loans if you go to these places, even if it's for a short period.

So really emphasizing the importance of those kind of programs for people in primary care can be very helpful and very significant. And even in mid career, young career, I think a lot of us physicians now are realizing, you know, we're not as financially astute as our other colleagues.

So, even when you are mid career or early career, still, the concept of financial management, even in institutions, you know, yes, we get all sorts of seminars, resources, et cetera, but I think hospital systems should also help their primary care providers by saying, you know, these are some financial management programs or et cetera. Again, I'm being very broad, but I do feel that people should be more astute about how they set up themselves financially. And also thinking about the flexibility of finances, people can get income in different streams. So just because you're a provider, physician or family care provider, there are many other ways you can get income, to supplement or to add whether the person is interested in real estate or, you know, there's a lot of income that can pretty much bring in revenue without you having to be so active. You know, not everybody is great with stocks, but I think that uh, that concept will allow people in primary care to feel comfortable if they have multiple streams of income. Again these, this kind of thing is not, we have colleagues in different fields.

And so, people who are in medicine don't have to be just so streamlined in terms of financial flexibility. So, I feel that's something that if it was emphasized more, people will feel more comfortable going into primary care or staying in primary care. So that's just an aside that I feel I always like to point out in terms of income for primary care and supplementing and feeling comfortable staying in the field.

In regards to burnout, as a mother who has young children that are transitioning in school, it's a reality. And yes, I do have a lot of colleagues, and yes, perhaps I'll say female colleagues who are in this stage of life, who it's a reality in terms of balancing family life and wanting to be perfect in your work, perfect at home, and a lot of the things that being a mother brings with it.

I feel that institutions, aside from what was mentioned, flexibility. And recognizing that, and I think more places are recognizing that too. Being flexible, allowing your staff to understand if you have concerns, bring them to your management, having managers trained to be flexible. If someone has a

concern, if someone needs something, or being astute, how can we make it work?

How, thinking outside of the box. Everything doesn't have to be the nine to five. And so that flexibility with management and also empowering staff to feel that they can bring ideas in terms of their schedule can be very empowering to making feel people feel less burdened. So, I feel that training or how empowering managers and physicians to think outside of the box in terms of how to organize their work life balance and not being made guilty to feel that way.

And it can be beneficial because even if people modify their hours, then they become happier, more productive, et cetera. So, I think that really in terms of flexibility with scheduling and flexibility with how work is set up can be empowering and can help with burnouts as it's occurring now.

I, hope we're at the nadir, but if things continue the way they are, I feel until the near future, just empowering people to think outside of the box in terms of their schedules and also in terms of medicine can be practiced in many different ways, and people can start thinking outside of the box on that as well.

Primary care can be practiced in many different ways, so people's flexibility, I feel, is going to be a key way people use to circumvent burnout and what's going on in society within healthcare.

Host: So normally as a host, I ask the questions, but I'm actually going to add a little bit here because I have this background. I started in primary care and then was in hospitalist medicine and then went back to primary care. And I just want to add a few things. First off, the pay is much better than it used to be.

It is far better and it's pretty good comparatively. And so especially when you get to those issues that uh, Ada, you're raising, you know a specialty fellowship is another three years, often maybe two, but three. And if you're doing a surgical, it's even it can be four or five, even up to eight for neurosurgery of training beyond, beyond medical school. Right. And so, you're getting out into the work environment on a full salary much quicker when you go into primary care, generally, after a three-year residency program and the pay is good by any measure. I do think that there have been significant improvements in work life balance in my career from when I came out as a resident, what was expected of me which was, pretty rough, to be honest.

Now what is expected of me? I don't find it all that challenging, partly because I was so used to the other model. But, I think work life balance is something that can be struck quite well within primary care. With any job you take in medicine is going to require things of you.

I mean, you're not being paid to do nothing. You're being paid to work hard and see patients and so forth. But, if we think of these jobs as largely weekday jobs, largely without a lot of evening responsibilities that know, it's very manageable. Oftentimes with time built in for administrative work, so you can follow up on your inbox issues.

And you know, it's also time that you could take your kid to the pediatrician if you have to and catch up with the inbox later. I personally don't find it that burdensome. So, I'm just going to throw that out there. I know that we're at the nadir of the perspective of primary care, but I think it's a great field.

I don't think it's any more difficult than any other. And I think the pay has improved dramatically. And there are opportunities for more pay both within the value-based framework that we did a couple of podcasts about, how that's changing. So, there's this whole pot of money that Insurance companies have historically sat upon, right, they're getting premiums from our patients, right?

And they're sitting on that money and then we're managing their health concerns and now there's this greater sharing of that pot of money with the providers who are actually protecting the patients and supporting the patients. And that's a big pot of money. It's actually a much larger pot of money than the actual money that is associated with just doing it, providing the services.

And so, as those models develop, I think, primary care, reimbursement will increase dramatically. I do think the other part of it, it just being somebody came out of an internal medicine residency and also for those that are coming out of family medicine residencies moonlighting is also an option.

And, as more and more jobs do not involve a lot of weekend work or nighttime work, and some of us were used to that coming out of residency, there are really some real opportunities to supplement with just clinical moonlighting. And uh, I've done that throughout my career I've learned a ton doing moonlighting and, also was able to afford some things here and there that were needed.

So, I don't find the salary issues to be as pressing certainly as they were back in the day, as they say.

Ada Emuwa, MD: Yes, I agree, and I am glad that you put some perspective there, which was why I really wanted to highlight that medicine changes and flexibility is always key and I described some of the concepts I had as ways that one can say, okay, medicine has changed in this because when I completed my residency medicine was different from, EMR, wasn't there.

There were paper charts. It was easy to kind of, easier to scribble and document and move on. And so, there were certain things that were easier to do to get through one's day and then fast forward to now, but there's always flexibility. So, like you're stating, there are different ways one can get different streams of income, et cetera. Different ways one can structure their day that may have been different from 10 years ago. But I, thank you for your perspective because it really highlights that thing of flexibility. I think if primary care providers realize, or in any field, that no matter what comes in, the environment, I can own my flexibility and I can say, okay, is there something additional I want to do? Moonlighting or coaching or et cetera? Or can I structure my day differently? In 10 years it'll be different. In another 10 years it'll be different. But the key is always to feel that you own your flexibility and you can always ask within your system and see what can change to allow you to go through that part of your journey in a comfortable way.

Joseph Teel, MD: And I think Kendal and Ada, I think if we think about granular examples, I think Kendal, to your point about we hope that people have free time and, and I think we're working towards increasing that free time. I think one example, for us even here at Penn Medicine is we are, our goal is to eliminate overnight call for all of our primary care clinicians and move that to a central model where patients can get virtual care 24-7.

But that the idea of all of us being on call at, on the weekends or the nights and we take turns and we cover for the practice and we get phone calls at two in the morning, I think is really going away. And we were moving already towards eliminating that. Several of our practices are already in the model.

It's been terrific. But I think to your point, then if, well, let's now, if I never have to take call, do I have opportunities? And Ada to your point, like with the idea of autonomy and flexibility, maybe I want to do some moonlighting or maybe I don't feel like I need to make more money and I'm just going to go learn how to dance or whatever it is that brings us joy.

I think the hope for all of us as we move forward.

Host: And I think we're getting into the next part of this conversation, and that is working for Penn specifically. I've had the benefit of working at two major academic health centers, both at the University of Pittsburgh Medical Center and now here at Penn, and the environments have been terrific.

Collegial, just constant education that is happening. Just a wonderful environment. So, I'm, very actually excited about the Penn one. I think Penn Primary Care is a wonderful place to work. So Joe, you know, you just highlighted one aspect, the after hours call is, being sort of consolidated into what we call Penn Medicine On Demand.

So, your patients, when they call in, unless there's something that they need to speak with you that's very specific in your relationship with them, but if it's just a new issue that has arisen, they'll be filtered through and set up to see Penn Medicine on demand. So now we're really protected in our non, non-clinical time as you said, allowing for other benefits.

Let's talk more about the Penn environment. Let me just say, I, think the pay is competitive certainly with other health systems. Joe, you can speak to that more than I. And there are opportunities for as Ada had elucidated, I think there are opportunities to stay at one's pay if you don't wish to work more, but there, and especially in a place like Penn, there are opportunities to somewhat dramatically increase one's pay if you are, you do need to, and you do want to work more than just the weekdays, for instance.

Joseph Teel, MD: Yeah, I mean, certainly that decision making capacity at different points in our lives, there are different priorities and the ability to decide to push a little harder this year and see some more patients and get the benefit of that, or maybe this year there's going to be something going on in your life or that allow that maybe you decide that it's time to cut back a little bit and I'm going to have to pay attention to some other aspect of my life or family. And so certainly that idea of autonomy is certainly a key, key aspect, Kendal, that I think is certainly a key element within employment at Penn Medicine.

And then certainly the idea that we have other support. So, we already mentioned Penn Medicine On Demand. You know, I'm leading a project right now that's being funded through a grant. There's a grant mechanism within Penn called the Clifton Wellness Fund that was set up to basically help find novel ways to support wellness within our physicians and clinicians.

And so, we are going to be studying, two different in-basket management strategies. One is an inboxologist model, which I think has been used elsewhere.

And it was, we'll be studying across both Lancaster General Health and the rest of Penn Primary Care. And sort of almost, I would say we're calling a modern template arm which is essentially accounting for all that extra work.

We know, every four-hour session or thereabouts can produce up to an hour of additional work afterwards, phone calls and results and all that. So, you know, how are we going to plan to do that work? This is all facilitated in the future and even now by these value based programs where if we don't have to be on that hamster wheel just worrying about fee for service dollars and RVUs all the time, how can we actually structure a day so that when the clock strikes five o'clock, you can roll up your sleeves, get out of there, shut your computer down and actually just go, pay attention to your life, your family.

And so, I think we're excited about the ability to really shift the effort into the daytime hours and relieve our clinicians of that after hours burden. So it's exciting to be engaged in that work this year.

Host: Ada, I'm going to let you jump in here if you have anything you want to add.

Ada Emuwa, MD: Yes, I took a few minutes to like really reflect what is it about working at Penn Medicine that really keeps me engaged and excited and my location now at Long Bistro General Health, I know one of the things that really drew me to the institution and at that time, we were already a group with Penn Medicine really, I, and know I keep saying that word, but as a mother and a wife and an individual in mid-career, that word of flexibility was really key to me and really attractive. And also the sense of connect to community. And so, working in a place where, you know, as my call, as he said, if this year if I want to work more and get more hours; there was flexibility to float and cover at other locations and sites. If for any reason I wanted to cut back for whatever reason, there wasn't that environment of being dinged upon or looked down upon. It was a that flexibility was there if you need it, let us know and we'll see how we can make it happen.

And that's one of the beautiful things that really attracts me and keeps me engaged at Lancaster General Health. and you can see that they keep keeping their managers engaged in terms of putting their finger on the pulse, checking in with staff. And so that's really is a key part.

And I know different people are drawn to different, you know, institutions for different reasons, but I, feel like in this age, with the generation of physicians that are coming into practice now, flexibility and wellbeing is key. And so

hopefully hearing that would be a strong motivating factor for looking at a place like Penn Medicine.

In addition, connection to community also was very important. The key to me, and at Lancaster General Health, they do have a presence in the community and a lot of programs and projects that they intentionally want to see their community better. And even towards Philadelphia, I could see that Penn Medicine also had such similar concept, insight, approach to how they connected with the community in terms of projects and collaborating with area organizations.

When one has been in the system for a while, they may not see it. I don't see that, but when you've been to different institutions and you come in, you recognize that there are levels. And so really I say that connection to community can be very key, and especially for a primary care provider, because that's kind of one of the things that you to primary care is, taking care of the family as a whole.

And so, understanding that you're part of an institution that takes that as a priority can be important for a lot of people. And especially when one is trying to think of taking care of a patient beyond just clinic. What's going on in their environment, what's happening in the community around where I practice.

So, I'll say connections to communities also something that I really applaud that Lancaster General Health and Penn Medicine as well takes, take steps towards, sincere steps towards trying to facilitate. And that can be important in primary care for a variety of providers. So hopefully a different perspective.

Host: I think one of the things that Penn Medicine does offer, because it now is a relative, it is a diverse. So, it's a very diverse um, uh, uh, uh, health network that really goes, obviously out to Princeton, out to Lancaster. And then within the Philadelphia's more specific region has suburban practices, has city-based practices that you really have an opportunity to practice to choose, I guess, to practice within a diverse range of environments.

And Penn has done a very nice job in the last 20 years and done it intentionally of really expanding its community-based presence. Joe, I think, just the Department of Family Medicine and Community Health and how that has grown and in its mission and its operations, really what it does within Philadelphia more specifically, but, even generally the university as a whole has prioritized developing community connections, and that has produced more opportunities. So, I've had friends and colleagues who have done obviously may

have a Penn based practice, but they're also actually working in a federally qualified health center, and they're having the practice base there, but they're paid for by Penn.

And then, of course, Penn has expanded its own practice into a larger variety of places. So, there's really a tremendous, my point is there's a lot of diversity and a lot of flexibility in the job you can create within the Penn environment.

Joseph Teel, MD: Yeah. I mean, it definitely, I think broadly for primary care and certainly specifically with MPEM medicine, what all of our jobs looks like are, look like are very different. And even through our careers, they look different. I think if you've probably looked at any of our careers, Kendal, you've already made reference to yours.

What we did a few years ago is, and so I think certainly within primary care more broadly and within Penn Medicine, that ability to adapt our career path over time is a huge advantage. And I think it also comes with the benefit of being part of a big health system. There's some flexibility, there's scope, there's resources that'll allow us, to have the privilege of making some decisions and trying things out and then figuring out where we fit at different points in our career.

Host: Two other things I want to highlight, and Joe, I want to have you comment on and Ada as well, is just in the work environment itself, the support staff. I personally feel very well supported and so in comparison to what I experienced 20 years ago, and I worked in a very, I think, a very fine program at the time. It's just that the support staff has dramatically increased since that time. Joe, maybe you can comment on what Penn's been doing in that regard.

Joseph Teel, MD: Yeah, I mean, I agree. I mean, since even just in the 14 years I've been at Penn, who's working around me looks totally different, right? Like you know, years past, it was basically me, the medical assistant and then a nurse was somewhere, answering phone calls or whatever it was and likely perhaps in a different building.

And then today you look around and certainly that core care team is still there, but, you know, it's, it's, it's, it's, it's, you know, absolutely there are more nurses around for most of us. We have a lot of expanded care team members. So, the fact that we have care managers, integrated behavioral health professionals there's a myriad of other in some departments, a myriad of other roles, so peer health or peer support specialists for individuals with, you can keep going down the list of the expansion of our care team has been tremendous.

Much of that change has been through value-based dollars and other novel payment mechanisms that allow us to focus on those. So, I think, again, it's, I think if we look at our landscape of primary care across the country and even at Penn Medicine, that idea of what primary care is these days has really adapted.

And it's been amazing to be part of that change and look around and feel much more balanced in my own life. It definitely feels better to have all the support around you. I don't have to worry about being a social worker and the behavioral health specialist at the same time while also trying to provide medical care. So really been a great transformation we've seen.

Host: One of my least favorite things in life are mindless form signing or mindless refills but I will say the support staff teased all that up. It happens very quickly and I don't find over myself overly burdened by it. So even on that sort of operating at the top of your license piece where, you're really doing the thing you went to medical school to do and you feel fulfilled by that, that a lot of the stuff that I think that maybe in the early 2000s or even 1990s, people were leaving primary care because they just were overwhelmed with the administrative bureaucracy. I don't see that anymore.

So, the last thing I wanted to tackle was literally the benefits of working in a Penn environment, not just sort of the qualitative benefits that we've been talking about, but the actual quantitative benefits, right?

So, obviously health insurance and other benefits come with having a good job. But there are additional benefits of working in an academic environment. I think tuition benefits is the main thing that comes to mind in that setting. Joe, can you speak to that?

Joseph Teel, MD: Yeah. So, I think this is where there's a little diversity in terms of where you're employed within certain health systems and certainly Penn Medicine that I think we have to acknowledge that some of the clinicians in our health system have some tuition benefits for themselves or dependents.

Others have slightly different benefits packages, but I think across the board, the ability to work for a system like Penn Medicine certainly brings some pros. When we think about compensation and sort of the, these sort of somewhat less common benefits where we were just talking about.

And so, I think when you look at employment with us, you're certainly, you know, we're, we talked about the pay already. We, I think we're competitive and I think being in primary care these days has gotten better, as you already

mentioned, Kendal. And I think choosing to be at a place like Penn Medicine also brings with it these additional benefits that when you're thinking about comparing a job A to job B, really, I would encourage all of anybody listening if you're in that job hunt to really start asking questions about what are the other things I can expect from my employer around some of the things you mentioned. There's also things within the health benefits people don't necessarily even think about necessarily early on, but I think really digging into those benefits and understanding what it means to be at a place like Penn Medicine from the total compensation and the total offer that you're being, that's being put in front of you is really critical.

Ada Emuwa, MD: In regards to the benefits, I wanted to add that there are additional ones as well that may seem obvious, but again, by being at a variety of different institutions, I can say the CME package here is a very, very competitive and very strong in regards to healthcare and healthcare benefits. Definitely something to look into because there are options where one may not necessarily need to pay anything extra out of your paycheck for health insurance and there are also a lot of other benefits as well in regards to, depending on your location, but there are many discounts that one can get, and again, if you, depending on your interests, but if you tap into that.

There are a lot of discounts for a variety of community events, locations that one can get through a variety of different locations such as here at Lancashire General Health. So, by the time you get the significant savings off these discounts amusement parks and plays and, fairs, et cetera.

Those things can add up, especially when you're trying to keep children entertained at childcare, et cetera, in terms of discounts one can get. So, a lot of healthy, and that's the benefit of being with a big organization. They're able to negotiate a lot of discounts. So, definitely something to look into as well.

And also access to financial planning, et cetera. If one wants to tap into that. There are a lot of resources that can be available. So, yeah, just wanted to kind of add to what was said in regards to benefits. And there are also opportunities for training. So again, every institution is different, but if one is interested in leadership training or in terms of this coaching, there are opportunities to be involved in things like that, and those are benefits that one can't quantify.

So those exist. So those are additional benefits as well in terms of career advancement that one can be involved in, in terms of personal development. So I wanted to add to that as well.

Host: Thank you, Ada. There's one other issue I want to say from a personal perspective, and then I'm going to invite actually Jessica McElroy, who is the Physician Recruiter for Penn, to just make some comments about some of the specifics of working at Penn. But I wanted to speak to those coming out of residency programs who are thinking about jobs in the future.

Many of us who train in residency train mostly in an inpatient environment, and then we're looking at jobs that would be in an outpatient environment, and maybe we're not completely comfortable. And so, I think that's funneling a lot of what could be very good primary care physicians into hospitalist medicine, and I was one of them for a while, and hospitalist medicine has wonderful benefits, and I enjoyed my career there.

But I think that there is still room for folks who want to do both, and the environment is changing, but I know hospitalist leadership within the Penn environment is open to ways that we can craft jobs that allow for some flexibility and so forth. It does depend on the location and so forth and the local location, but for those folks coming out of residency and are interested in still doing both inpatient and outpatient medicine, I think there's some opportunities there at Penn.

So, with that Jessica, you've been listening in, Jessica McElroy is the Physician Recruiter for Penn. You've been listening to our discussion and, and I just want to ask if there's anything you would like to add.

Jessica McElroy: Thanks so much. So, I lead provider recruitment, physician recruitment for the non-academic regional practices across all of Penn Medicine. My career interest is really to look at the physician as an individual and identify the right place and the right time for them based on what's going on in their life, understand who they are and what their interests are from a clinical perspective, patient perspective, from a practice perspective as well as from a professional and growth perspective. Penn Medicine has an academy that focuses on leadership development as well as a career trajectory to kind of be a lead clinician or a regional leader. You know, Dr. Teel in his particular role as the Regional Chief and many other capacities within the organization where somebody can start in and stay in their career.

From an overall benefits perspective we have a very rich benefits package and think that we have a competitive compensation package that focuses on things like productivity and quality incentives. And those are really kind of current with what's happening in the overall primary care marketplace.

Some of the unsaid benefits that people want to think about in more greater detail are focused on things like wellness, things like their clinical time and how they spend their time outside of seeing patients. And we hope to continue to work at that. It's actually on our strategic plan.

So, our goal is to be the most clinician friendly health system and we have a lot of work ahead of us and already underway to get us there.

Host: Well, thank you, Jessica. Thank you, Ada. Thank you, Dr. Teel for all, everyone for joining this discussion. We just wanted this to be an opportunity to talk, to recruit a little bit to both primary care generally, but also to the Penn environment. So, thanks for allowing us to do that. We're going to be diving back into clinical topics next time.

So please join us again next time for the Penn Primary Care Podcast.