Specific issues.

1. Patient referral problems are a recurring theme among clinical faculty. Virtually everyone complains of the inability to have patients seen in the subspecialty clinics in a timely manner. The subspecialty clinics complain that UCSF primary care patients come with inadequate documentation, noting that UCSF primary care notes are generally not in STOR and, therefore, are unavailable to the specialist. It is also difficult for outpatient physicians to access ED notes.

2. All of the disciplines are trying to cope with coverage and educational problems related to the 80 hours and 6 days per week, 36 hours-in-a-row coverage limitations.

3. All the clinical services report some problems with UCCare that relate largely to the difficulties in launching any new system.

4. Billing and reimbursement issues, such as specific third party billing requirements, the financial and legal implications of attestation notes, timely reimbursement from in-patient services, are all of concern.

5. It has been suggested that there is a lack of collegiality among the faculty that makes it difficult for new or junior faculty to navigate the intricacies of the UCSF clinical bureaucracy. One faculty has even volunteered to set up a regular program to help introduce new faculty to the UCSF system.
General issues.

1. Increased demands on in-patient services, particularly relative to the shortage of medical beds, has had a major impact on referral and practice patterns on all of us. Obviously, this an issue of University/Medical Center resources, not just a concern of the CAC.

2. There is not enough support for clinical work, especially for the junior faculty. One hand junior faculty are expected to provide clinical services, yet it is clear that clinical work does NOT enhance academic standing and may, in fact, impede academic advancement. Also, one cannot support one's salary by clinical work in an academic setting. The university cannot expect their clinical faculty to provide clinical services, teach, and do research without augmenting financial support.

3. The University and the Medical Center need to define which population they intend to serve. Should we serve just as a tertiary referral center? Are we to provide primary care to the people of California or San Francisco? Should Parnassus Heights be primarily a surgical subspecialty center?

4. What does the Academic Senate expect of the Clinical Affairs Committee? Are we simply a conduit through which Academic Senate, University, and Medical Center information is passed onto the clinical faculty, or are we an advisory body, intended to provide clinician input to the leadership regarding clinical affairs before decisions are made? If we are meant to be an advisory body, at this juncture we have neither the influence nor the empowerment to be affective advisors.