



The Future of CAP is in Good Hands

More than 40 years ago, the founding members of the Cooperative of American Physicians put their trust in each other to find a viable and alternative option to access affordable malpractice protection. These accomplishments became the foundation for CAP's future success.

Today, CAP's more than 12,000 physician members benefit greatly from the financial strength and security the Mutual Protection Trust provides in the form of medical professional liability coverage. Capitalizing on decades of disciplined oversight, CAP members rely on the expertise of their leaders to continue this legacy of trust.

As our biennial election approaches, 12 physician members have been nominated by the CAP and MPT Boards to serve the membership. We invite you to learn more about this diverse pool of physician candidates who hope to have the privilege of supporting you and your practice and guiding the organization into the next era of strength and service.

Please keep an eye out for your election voting materials, which are being sent under separate cover. Your prompt vote will help minimize the expense associated with the annual meeting.

CAP Board of Directors

May 2019



Name: Sheilah M. Clayton, MD

Medical School: Case Western Reserve University School of Medicine

Practice Location: Pasadena, CA

Specialty: General Surgery

Years in Practice: 29 years

CAP Member Since: 1990

As a female surgeon in solo practice with experience serving on various CAP committees and the Board of Directors, I am committed to delivering on the organization's promise to provide outstanding practice protection and support. I understand the unique challenges independent physicians experience in our turbulent market and know we can rely on CAP to help us with added benefits like insurance, risk management, and practice management services. As a member of the board, my goal is to build upon CAP's success and represent the voices of our members in shaping the future of the enterprise.



Name: Roger S. Eng Jr., MD, MPH, FACR

Medical School: George Washington University School of Medicine & Health Sciences

Practice Location: San Francisco, CA

Specialty: Radiology

Years in Practice: 22 years

CAP Member Since: 2016

My 25 years in organized medicine includes three terms as a member of the California Medical Association's Board of Trustees and a one-year term as president of the San Francisco Medical Society. Understanding how to effectively represent the interests of thousands of physicians of varying practice settings and specialties will prove valuable in serving on CAP's Board of Directors. I am interested in working with CAP members to develop resources around artificial intelligence, hospital-based practices, integrated health systems, and health IT. On behalf of my Northern California colleagues and CAP members throughout the state, my priority, if elected, will focus on enhancing physicians' practices and developing resources that go beyond malpractice coverage.



Name: Dennis T. Jordanides, MD

Medical School: Texas Tech University Medical School

Practice Location: Newport Beach, CA

Specialty: Internal Medicine

Years in Practice: 19 years

CAP Member Since: 2007

Optimism, compassion, a pragmatic problem-solving approach, and the passion I have for clinical medicine are qualities I will bring to bear as a member of the Board. I firmly share in CAP's vision to help doctors do what they do best: care for patients. As a current member of CAP's State Political Action Committee, I am committed to working alongside our strong and devoted leadership team to continue to develop and advocate for the resources that solo and small group physicians need to be successful.



Name: Wayne M. Kleinman, MD

Medical School: Medical College of Virginia, Virginia Commonwealth University

Practice Location: Tarzana, CA

Specialty: Anesthesiology

Years in Practice: 30 years

CAP Member Since: 1992

As a physician with an active practice and in my current role as your president and chair of the CAP Board of Directors, I understand the struggles and frustrations physicians experience. My goal in serving the organization is to ensure that members are treated fairly, vigorously defended against frivolous lawsuits, and offered financial protection when needed. This can only happen if CAP's strength and long-term stability continue to strengthen through new membership, disciplined underwriting, and proactive risk management. As part of CAP's leadership, it is both my honor and responsibility to safeguard the long-term viability of the organization and in doing so, keep our shared risk an absolute priority.



Name: Greg S. Lizer, MD, FAAP
Medical School: Hahnemann University
Practice Location: La Cañada, CA
Specialty: Pediatrics
Years in Practice: 22 years
CAP Member Since: 1997

During my 25 years as a physician, I've seen incredible changes and challenges affecting medicine and have been fortunate to experience our healthcare system from the perspective of medical practices, medical groups, hospitals, and payors. CAP is unique in the level of support and protection it provides members, which is grounded in the organization's strong financial footing and genuine interest in listening to its membership. As a Board member, I derive great satisfaction in helping our members meet their needs and goals, ultimately for the benefit of their patients.



Name: Graham A. Purcell, MD
Medical School: University of Alberta Medical School
Practice Location: Los Angeles, CA
Specialty: Orthopedic Surgery
Years in Practice: 48 years
CAP Member Since: 1989

Having served on various CAP committees since 1991, I have acquired valuable institutional knowledge and experience, which have given me the opportunity to help the organization achieve our mission to offer our members the highest quality, most cost-effective malpractice protection possible. I believe that CAP's success is rooted in a long history of steady growth propelled by the shared vision of physicians who seek solutions to issues threatening the practice of medicine. With your support, I will continue to serve in the best interests of our members.



Name: Paul Rocky Weber, MD, PhD
Medical School: Jefferson Medical College
Practice Location: Long Beach, CA
Specialty: Obstetrics and Gynecology, Infertility
Years in Practice: 38 years
CAP Member Since: 1981

As a member of the peer review and risk management committees at Long Beach Memorial Medical Center, and as the former chief of staff and chief of obstetrics at Women's Hospital, I am empathetic to the complexities physicians face in navigating safe patient care in our complicated healthcare system. I also understand the expectations physicians have for their medical professional liability. My interest in continuing to serve on CAP's Board of Directors is driven by my commitment to the quality control, recruitment, and peer review of our members, and the ongoing tradition of CAP's personalized approach to the resolution of claims.

MPT Board of Trustees



Name: Othella T. Owens, MD, FACS

Medical School: Medical College of Virginia, Virginia Commonwealth University

Practice Location: Los Angeles, CA

Specialty: Otolaryngology - Head and Neck Surgery

Years in Practice: 36 years

CAP Member Since: 2007

Having held leadership positions with a variety of organizations including CAP, I remain committed and well-prepared to work with my colleagues to achieve CAP and MPT's strategic goals and objectives with integrity, and to secure the future health and strength of the organization. As physicians face and respond to mounting industry challenges, it is crucial that we remain flexible in deploying staff, service, and products to support our members' commitment to excellence in the practice of medicine. I am ready to accept these challenges we all share and ensure our strong future through the faithful stewardship of MPT's assets and protection of its members.



Name: Stewart L. Shanfield, MD

Medical School: University of Texas Health Science Center

Practice Location: Fullerton, CA

Specialty: Orthopedic Surgery

Years in Practice: 33 years

CAP Member Since: 1998

My goal in continuing my service on the MPT Board of Trustees is to maintain the powerful voice of our organization in the medical community, protect our resources, and provide representation and support for our esteemed members. I share the perspective of my fellow leaders that close collaboration with our membership enables us to support our vision to overcome the healthcare challenges we all face in our practices. I am the former board chair and chief of staff at St. Jude Medical Center. I have also served on CAP's Audit and Finance Committees since 2007 and was a board member of Fullerton Community Bank since 2001. Given my experience, and as your Finance Committee chair, I am committed to protecting MPT's fiscal resources and CAP's position as one of the top providers of coverage in California.



Name: Charles P. Steinmann, MD, FACA

Medical School: University of California, San Francisco School of Medicine

Practice Location: Newport Beach, CA

Specialty: Anesthesiology and Pain Management

Years in Practice: 45 years

CAP Member Since: 1981

I am proud of my 30 years of experience with CAP. As past chair of the Finance and Audit Committees, a former member of the CAP Board of Directors, and current chair of the MPT Board of Trustees, I have witnessed and contributed to the milestones CAP and MPT have achieved to become the strong and stable organizations they are today. Confident in our disciplined practice of financial conservatism, efforts to protect MICRA, and achievements in helping physicians run more successful practices, I am unwavering in my commitment to serve our membership and sustain our growth and stability.



Name: Lisa L. Thomsen, MD, FAAFP

Medical School: University of California, San Francisco School of Medicine

Practice Location: Glendora, CA

Specialty: Family Medicine

Years in Practice: 29 years

CAP Member Since: 2003

I believe in CAP and MPT and the strong work the enterprise performs in supporting and providing resources to our members. That is why it has been my pleasure to serve on the CAP Board of Directors and Member Engagement and Education Committee, among other roles. As physicians continue to navigate the ever-challenging medical landscape, I look forward to bringing my full-time, active clinical perspective to the MPT Board of Trustees, so that our enterprise may continue to grow and our members are properly protected and supported.



Name: Phillip Unger, MD

Medical School: University of Manitoba

Practice Location: Fullerton, CA

Specialty: Radiology

Years in Practice: 44 years

CAP Member Since: 1978

During my time in practice, I have served in numerous leadership positions — including CAP and MPT — and have been passionately interested in delivering high-quality, cost-effective medical malpractice protection for my fellow California physicians. CAP continues to respond to the rapidly changing needs of physicians as healthcare continues to evolve. We have created solutions that cover large medical groups and have developed a host of services and benefits to help solo and small group physicians prosper. I have been actively involved in guiding many of the recent CAP and MPT enhancements and would like to continue to address future challenges.

Risk Management — and — Patient Safety News



CMS Modernization: Telemedicine and Virtual Care

by Michael Valentine, JD, CPHRM

The purpose of this brief advisory is to highlight risk issues — documentation and consent — associated with recent reimbursement expansions created by the Centers for Medicare and Medicaid Services (CMS). More comprehensive analysis of the changes, including rules, limitations, and other specifics is available at <https://www.cms.gov/newsroom/>.

Background

The Digital Revolution has changed and is continuing to change medicine. There are many drivers of these changes: digital/technological advancements, changing demographics, and societal shifts to digitization. Simply put, we function and communicate more via remote-utilizing technology. In response to this changing landscape, CMS modernized its Medicare physician payment plan and quality reporting program effective January 1, 2019. Reimbursement opportunities for communications-based services, also known as telemedicine and virtual care, have been expanded, which will have a corresponding effect on the associated risks.

Highlighted Aspects of the Medicare PFS Changes

Reimbursement was expanded for technology and communications-based services such as telephonic, internet, photo submission, and inter-professional consultations. Separate payment codes for Internet/telephone consultations between treating and consulting practitioners were created. Chronic

care remote monitoring and prolonged preventive care codes were added. Starting July 1, 2019, the beneficiary's home will be a permissible originating site for telehealth treatment of substance use disorders or a co-occurring mental health disorder.

Documentation requirements have been reduced. Practitioners do not need to re-record elements of the history and physical when there is evidence (i.e., documentation) that they have been reviewed and updated. Practitioners are required to document that they have reviewed and verified the chief complaint(s) and history that was already recorded by ancillary staff or the patient. Practitioners do not need to document the medical necessity for furnishing visits in the home instead of the office.

Risk Management Issues



Documentation

Documentation is always an important patient safety/risk issue. Documentation is sometimes the only form of communication amongst providers and with staff, and is almost always the only

communication with CMS and other reimbursing entities. It is one of the most, if not the most, significant issue for supporting and defending care. Always remember the maxim: if it is not in the chart, it did not occur.

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Telemedicine, remote, and virtual care will evolve some of its own “feel” because they are new fields that are different from conventional office-based practice. However, the basic rules are the same. Be sure to document date, time, means of communication, use of interpreters, consent, review of chief complaint and history and physical, assessments, treatment planning, medication, referrals, prescriptions, follow up, and other relevant medical information.



Consent

Consent has always been the cornerstone of good medical care and is a fundamental patient right. The recent CMS changes have not changed that, but they have expanded

their application. When an inter-professional consultation is obtained via telephone/internet/electronic health record, the services are being obtained without the beneficiary patient present (to the consultant). This means that the patient must be informed of the consultation, give consent, and documentation of the same should be done.

Conclusion

CMS recognizes that the increasing use of digital technology has changed the delivery of care and requires corresponding changes in reimbursements. This is just a brief overview of the variations on age-old risk issues like documentation and consent that these changes bring. We recommend that you further research these and other changes so that you may continue to provide the best patient care and outcomes in your practice.

If you are a CAP member planning to start a telemedicine practice, it is important to contact CAP's Membership Services Department at 800-610-6642 to discuss coverage and special instructions. For other information, please go to CAP's website at:

<https://www.CAPphysicians.com/articles/telemedicine-risk-management-strategies>. ↩

Michael Valentine is a Senior Risk Manager for CAP. Questions or comments related to this article may be directed to mvalentine@CAPphysicians.com.

May 2019



Life Insurance Dos and Don'ts

by Ravi Davis, CFP



Physicians come out of medical school highly educated and anticipating a career that will be rewarding in every way — including monetarily. Not surprisingly, this makes them perfect targets for people who sell life insurance.

Doctors have more money than time, and are justifiably proud of their ability to grasp complex subjects quickly. But what life insurance agents know that most doctors don't is that there are a wide range of life insurance products available – and that the most expensive, most profitable products may not be the best ones for every doctor in every situation. When it comes to medicine, the average doctor knows far more than the average life insurance agent ever will. But when it comes to life insurance, it's surprisingly easy to get fooled, unless you're willing to take the time to really dig into the details and know the right questions to ask.

Life Insurance Basics

There are three main kinds of whole or permanent life insurance: traditional whole life; universal life; and variable universal life. But it gets confusing fast, with variations, sub-types, and sub-categories.

Doctors are aggressively sold cash value (permanent) life insurance, which combines an investment product with life insurance. It often sounds appealing to young doctors who don't have time to invest.

These are really profitable policies for the agent to sell, for a number of reasons. First, these policies are complex, with substantial downstream potential tax implications for funding or not funding the policy at specified levels. Second, there are fees that really add up over time.

These policies cost much more than term life insurance, which is more straightforward. It's like car insurance – pay every month and hope you'll never use it.

It's called "term" insurance because the policy has a specific monthly cost for a specific term. Rather than an open contract that runs for life, you choose a 10, 20, or 30-year term.

When should you buy life insurance?

It's best to buy when you're young and healthy, to lock in a long-term strategy.

Buy when you have dependents: a spouse, children, or parents who are dependent. You'll need more life insurance when you're young, and the family can't afford to lose your income. You'll need less as you get older, although it sometimes needs to be considered when estate planning.

How much life insurance do you need?

If you're 27 and engaged, consider a policy that pays \$2 to \$6 million dollars. If you're in a surgical specialty you may need more. On your death, that money is paid as a lump sum, tax-free. Think about what you need the life insurance to do. How much does your spouse earn? How high is your mortgage? Do you need it to provide income for your spouse?

It's good to diversify

Buy from different insurance companies and "stack" your coverage: a 10-year term policy from one firm, 20-year term from another, and a 30-year term from a third. As your wealth grows and risk shrinks, you can pare your coverage back.

Summary: Life Insurance Dos and Don'ts

- **Do** talk to a broker or independent agent. They work for you, not the life insurance company. They'll help you navigate the complexity.
- **Do** work with brokers or independent agencies that specialize in working with doctors.
- **Don't** speak only to a captive agent who works for a life insurance company. Their incentive is to sell you the most profitable policy they can.
- **Do** buy term insurance — it's the right answer 95 percent of the time. ➦

Ravi Davis is founder of Hippocratic Financial Advisors, an organization dedicated to growing physician's financial health and well-being.

Healthcare Expansion Efforts Turn Incremental

by Gabriela Villanueva



While discussion of universal healthcare (also known as “single payer”) will likely continue at the national level, here in California, proposals emerging from the Governor’s Office and from legislative policymakers indicate a turn to a more measured, incremental approach toward increased healthcare accessibility, affordability, and coverage.

In January, Governor Gavin Newsom released his state budget proposal for the 2019-2020 fiscal year. Since then, some of his health-related items have been working their way through the legislative process in anticipation of the Governor’s budget revisions released in May (traditionally known as the “May Revision”). The May Revision is a very telling document, as it generally presents a clearer picture of which proposals, especially new spending proposals, are having some success moving toward actual implementation.

Having seen the Governor’s more progressive budgetary priorities focus heavily on healthcare, policy makers have set forth similar but not identical goals. If there is a compromise between what the governor proposes and what legislative leaders adopt, the final

legislative language will likely be written in the budget trailer bill process, potentially up until the mandated June 15 deadline to pass the state budget. Items currently moving through the legislative process to watch include:

- **SB 29/AB 4 — Increasing Medi-Cal Coverage (Sen. Durazo, D-Los Angeles/Asm. Arambula, D-Fresno)**

These bills would extend Medi-Cal eligibility to all income-eligible adults regardless of their immigration status. The Governor’s proposal on this issue is limited to young adults ages 19–25 years old.

- **SB 65/AB 174 — Affordability (Sen. Pan, D-Sacramento/Asm. Wood, D-Santa Rosa)**

These bills would require Covered California (the state’s federal health exchange) to provide more financial help to low-income residents buying insurance through the exchange. The Assembly bill would establish a tax credit beginning in 2020 for individuals between 400 and 600 percent of the federal poverty level. The Senate bill requires Covered California to reduce copayments and deductibles for people with incomes between 200 and 400 percent of the federal poverty level. Both of these bills would match Governor Newsom’s proposal to establish an individual mandate for California residents, including a state-level penalty for people who do not carry health insurance. Revenue generated from the penalties would fund subsidies in Covered California plans with the aim of increasing affordability. ↩

Gabriela Villanueva is CAP’s Public Affairs Analyst. Questions or comments related to this article should be directed to gvillanueva@CAPphysicians.com.



Asset Protection: Personalized Attention for CAP Physicians

CAP Agency certainly hopes you and your family were not affected by the fires in California last year. When disasters like this happen, it is always an opportunity to reflect on your personal insurance. Once we get the coverage for our homes, we often forget to review it regularly to make sure we still have the protection we need if something were to occur. We want to be sure if something does happen, you will be able to replace your home and all personal assets.

When it comes to protecting your personal assets, you deserve the same expert, trustworthy, personalized attention from your insurance broker that you give to your patients. That is why CAP Physicians Insurance Agency has partnered with Integro's Private Client Group as your strategic partner committed to delivering superior service. We are available whenever you need us, and confidentiality is always guaranteed. Laura Schneider is our Integro Personal Lines expert who will review your program on an ongoing basis to evaluate potential revisions in response to economic changes, market trends, or changes in your needs.

Custom Services Designed for CAP Member Physicians

Significant personal assets require higher levels of protection, often with uncommon coverage requirements not available on standard policies. Because your needs are unique, we work with you to create a plan designed specifically for you. As a Cooperative of American Physicians member, you are eligible to receive an offer for a variety of personal, traditional, and specialty coverages, including:

- Home and Auto
- Vacation Homes and Rentals
- Fine Art, Jewelry, and Collections (including wine)
- Recreational Vehicles
- Yachts and Watercraft

- Private Aircraft
- Gentleman Farming and Wineries
- Personal Umbrella (provided through CAP's group program)

Group Personal Umbrella

Most of us do not like to think about the possibility of something bad happening to us or our family members, such as an automobile accident, slip and fall, or someone drowning in your pool. Bad luck can strike at any time, and inadequate liability insurance coverage can prove to be financially devastating.

As a physician-owned cooperative, CAP is able to secure exceptionally competitive rates through a Group Personal Umbrella insurance program with an A+ rated carrier, Chubb, which sits on top of your homeowners and automobile coverage to ensure you have adequate protection. This coverage applies to all family members residing in your residence

For example, as a member of CAP you can purchase a policy that provides three million dollars in excess liability coverage for \$675 per year. Additional limits are available at the same low prices, up to 20 million dollars in excess liability coverage. CAP's personal umbrella coverage also includes, at no additional cost, one million dollars in uninsured and underinsured motorist coverage. No underwriting is required, just complete the enrollment form, pay the premium, and you are covered. It's that easy!

To learn more about these great offerings, simply visit <https://www.caphysicians.com/personal-insurance> to review coverage options and complete an online application. Or call us at **800-819-0061**. ↩



CAP PHYSICIANS INSURANCE®

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May 2019

PHYSICIAN'S GUIDE TO CHOOSING THE RIGHT INSURANCE




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How Much Insurance Do You Really Need? Free Guide Provides Help to CAP Members

So why not make different choices and be vigilant about protecting your income, assets, and well-being?

Understanding that navigating through what might seem like an endless sea of insurance options can be a daunting and time-consuming chore, CAP created *The Physician's Guide to Choosing the Right Insurance*, which outlines physician-specific insurance programs, what is covered in each, and how to know what is right for your practice.

When seeing patients, the physician's practice is no place for taking chances. The same goes for running a unique business like yours. Customization is key when securing the right insurance and the first step is understanding the options available.

Get the free guide today and discover a convenient and easy way to approach your insurance portfolio. To get your copy, please call 800-819-0061 or email CAPAgency@CAPphysicians.com.

As a physician, you handle patient diagnoses with due diligence, taking the right steps to consult with peers, order the right tests, analyze results, and offer the best guidance for safe and effective treatments.

Yet, many physicians do not practice the same diligence when safeguarding themselves or their livelihoods. Sometimes, it is easier to ignore the "what ifs," maintain the bare minimum, and keep your fingers crossed that all goes well. Would you use the same approach treating your patients? If you knew your patients had higher risk factors for certain diseases, you would encourage them to make different choices.

The experts at CAP's Physicians Insurance Agency, Inc. (CAP Agency) know that physicians and their businesses are at higher risk for a variety of threats like workplace accidents, HIPAA violations, data breaches, personal lawsuits, and many others. They also understand that physician practices have very different insurance needs than regular businesses.

Case of the Month

by Gordon Ownby



When Pain Medication Challenges Mount, Implement a Plan

Over the past 25 years, physicians have faced a distinct change in attitudes on prescription pain medication. Policy discussions in years past to promote more liberal use of narcotics have been replaced by the current war on opioid addiction. To be sure, a physician attempting to assist a patient on long-term pain medication faces special challenges.

Dr. FP, a family practitioner, had been treating his patient for a number of years for a variety of medical complaints, including back pain. When the back pain became chronic, Dr. FP's initial treatment plan included Oxycontin 40 mg three times a day and Flexeril. Two months later, Dr. FP received a letter from the patient's orthopedic surgeon, who noted the patient had a tolerance to narcotic medication and who urged Dr. FP to take the patient off pain meds while he prescribed a Lidoderm patch. Shortly afterward, the patient refused Oxycontin and Dr. FP prescribed Ultracet and Tramadol for pain.

On Dr. FP's referral, the patient saw a pain management physician a year later. That specialist advised Dr. FP that their patient was on Norco for breakthrough pain, plus Cymbalta and Soma. The patient did not continue to treat with the pain specialist, and about three years later, Dr. FP had to disapprove a refill for Soma until the patient agreed to stop taking the medication in excess of prescribed amounts.

The next year, the patient's health insurer wrote to Dr. FP about the possibility of the patient's

inappropriate use of controlled substances and an indication that the patient was receiving Norco from a different physician. Though Dr. FP discussed that he would not prescribe medications in addition to those she was receiving from another physician, Dr. FP's chart did not reflect such discussion.

Two years on, a neurosurgeon wrote to Dr. FP detailing an exam of the patient showing stenosis and facet disease at L4-5 and L5-S1. The neurosurgeon spoke to the patient about her seeing a pain medicine specialist to wean her off oral opiates. Dr. FP's chart did not show any efforts to taper her off pain medications, but on Dr. FP's referral, the patient saw another pain management specialist several months later.

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That specialist's assessment was that the patient was dependent on Dilaudid and his plan was to stop the Dilaudid and change her to Methadone. The specialist expressed his view that based on his exam and MRI, the patient did not warrant using excessive narcotics to control pain.

The patient continued to treat with Dr. FP and on several occasions, expressed a desire to get off her medications. The patient's daughter told Dr. FP of her concerns about her mother's use of narcotics. At one point, approximately 10 years into the back pain issue, Dr. FP unsuccessfully attempted to taper the patient's opioids by prescribing Clonidine and Propranolol. In year 11 of the issue, Dr. FP prescribed Oxycodone 100 mg four times a day, 350 mg of Soma three times a day, 75 mg of Lyrica twice a day, and 250 mg of Zoloft daily. At this time, Dr. FP referred his patient back to the second pain management specialist because of his concerns over the patient's drug dependency.

Five days later, the patient's daughter found her at home face down on the couch, unresponsive.

The coroner characterized the patient's death as accidental and attributed Oxycodone toxicity as the cause. In a subsequent lawsuit, the daughter alleged Dr. FP prescribed medication at fatal dosages and missed multiple opportunities to make things better. In his deposition, Dr. FP said he disagreed with the coroner's conclusions, testifying he believed his patient's death was from a heart attack or suicide. The lawsuit resolved informally without a trial.

Whatever the public policy environment on pain relief, when a family practitioner's treatment triggers alerts from consulting specialists, pharmacies, and health insurers about a patient's potential for drug dependency and abuse, a specific plan or "contract" may be a benefit to both. ⚡

Gordon Ownby is CAP's General Counsel. Questions or comments related to "Case of the Month" should be directed to gownby@CAPphysicians.com.

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