GENERAL MEDICAL INFORMATION TO HELP IN MEDICAL DECISION MAKING

A FALL OLLI COURSE (2301)
THURSDAYS FROM 9:30 TO 10:45

RICHARD G. WENDEL MD, MBA
MODERATOR

LOOKING BACK ON THE CHANGES IN HEALTHCARE AND THE PRACTICE OF MEDICINE DURING THE PAST 63 YEARS

Overview of the Change

1961	2024
Small Independent practices with many soloists practitioners with downtown offices.	Large Single and Multi-Specialty Group Practices with 4-600 practitioners (Hospital or Private Equity Owned)

Changes Continued

- 'Pill hill' in Clifton where all major hospitals were located. (within a mile radius)

- Scattered suburban hospitals and outpatient surgery and emergency care facilities.

More Changes

1. Few physician-extenders like Nurse Practitioners, and Medical Assistants
2. Osteopaths were considered second rate practitioners
3. Physicians were members of multiple medical staffs.

1. Widespread use of nurse practitioners, medical and physician assistants.
2. DOs given equal status
3. Physicians with privileges at a single Hospital System

More Changes

1961

1. Independent Physician decision making with little oversight.
2. Paper Charts with limited documentation
3. Private Self-Pay: cash over the counter

2024

1. Government, Insurance Co. & Hospital, OSHA, CLIA, HIPPA oversight and regulations
2. Electronic Automation (EMR, coding, billing)
3. Health Insurance, Medicare, Medicaid (complex maze)

More differences

1. Organized Medicine (AMA, OSMA, and Medical Societies) usually crafted public policy, reimbursements with limited oversite
2. Lower Tech with fewer tests
3. Physician Trust and continuity with one provider

1. **Government, and many deep pocketed interests influence public policy, oversight and reimbursements**
2. **Higher Tech with many tests**
3. **Eroded Dr/Patient Relationship with many specialists**

More differences

Organized Medicine (AMA, OSMA, and Medical Societies) usually crafted public policy, set fees, and self-policing

Government, Insurance Companies and many deep pocketed interests influence public policy, oversight and reimbursements

More Differences

1. More Affordable with charity care
2. Lower Tech with fewer test (lack of imaging like CT and MRI.

1. Very Pricy with rising cost curve above inflation
2. Higher Tech with many tests

More differences

Doctor/patient relationship was more seamless and trusted with PCPs following their patients when admitted to the hospital

Diluted Doctor/Patient Relationship with large group practices, restricted hours, and explosion in number of specialties and PCP do not follow their patients in the hospital (Advent of Hospitalists)

More Differences

Medical care as a Privilege	Medical care as a Right

The Office Practice in 1966

a. Cash over the counter business, POS
b. On job training—No office managers
c. Cottage industry
d. No record keeping requirements and coding specialization
e. Sterilization procedures for instruments
f. Fee schedules (RV guidelines)
g. Waiting times
h. Telephone Communications only
i. Doctors as unsophisticated investors

The Hospitals in 1966

- **All on Pill hill (Christ, Deaconess, Good Sam, Bethesda, Jewish, University, Holmes, Children's)**
- **Very small administrative staffs**
- **Hospital as the center of the universe for the Doc**
- **Staff privileges and politics**
- **Long Lengths of hospital stays; nurses could cover 10-25 patients because lower level of care.**
- **The doctor's lounge (a good old boy's fraternity)**
- **JCAHO**
- **Shortage of beds during flu season**

Organized Medicine in the 60s

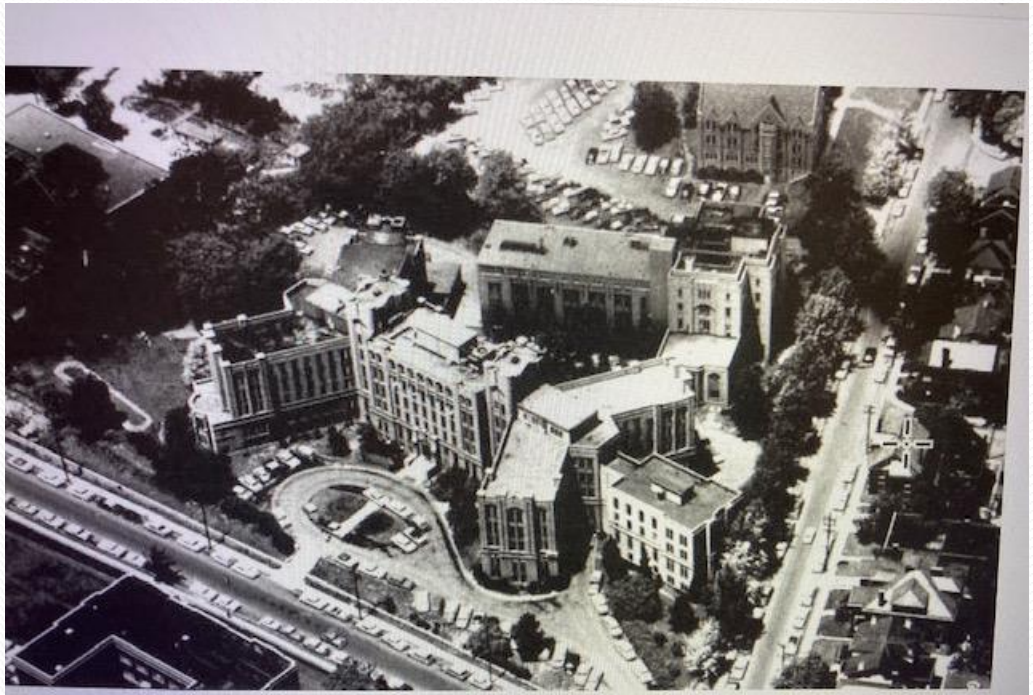
- **Privilege to belong to the AMA, OSMA and Academy of Medicine**
- **Cincinnati Academy of Medicine**
- **Role in setting public policy (committees)**
- **Specialty Societies (about 20) and Board Exams (oral and written)**
- **No CME Requirements**
- **Board of Regents at the State Level**

U.C. Medical School in 1961

- One small building on Eden Avenue
- Eighty-five students, **just five women**, one minority
- Few basic researchers for preclinical years
- Volunteer faculty and departments for clinical years
- Tuition ($990 per semester) and medical books
- Ohio State Board exams (Blue Books)
- Library and research (Medicus Indicus)
- Suture room, practice on other students

The U.C. Medical School 1960

The Children's Hospital Complex



Cincinnati Children's Hospital, built in 1926, from the air, in the 1950's

Advertising was prohibited

- **Considered unethical**
- **New physician announcements only**
- **No direct to the consumer advertising (came in during the early 1980s)**
- **Some gifts and trips for medical students and doctors and copious free samples**

The Old Cincinnati General Hospital

- **Patient mix(primarily indigent and charity care)**
- **Pavilion Architecture connected by Tunnels**
- **Open wards**
- **H1 & H2 Contagious Wards**
- **Op permits or Pink Slips**
- **The Holmes Hospital**
- **Rotating Internships**
- **Evening supper**

Internship and Residency Training

- Rotating Internships (majority)
- One year of surgery and three years of urology
- Responsibility came early; **see one, do one, teach one**
- Chief resident as master of the ship. (called in attending staff only prn.)
- Few if any female surgeons
- All Surgical Subspecialties under the Department of Surgery
- Rotations to the VA and Drake (Residents made 100 dollars per month.)

The Advent of 3rd Payers/Insurance

- Medicare 1965—Usual Customary Fees and Relative Value Scales. (windfall for the physician)
- Originally, with Health Insurances-patient paid physician first and then filed insurance. Blue Cross Blue Shield
- Health Insurance came of age with HMOs, PPOs, Managed Care Organizations in the late 70s with the promise of improved quality and cost containment (cost structures)

The Doctor/Patient Relationship

Why has it deteriorated over the years even as medical care has dramatically improved with much better outcomes?

- Specialization (120+ specialties), menu of doctors
- Assembly line type physician incentives (15 minutes per established patient) encourage the physician to short-change the patient
- No house calls and mobility of our society
- PCPs no longer follow their patients in the hospital (hospitalists)
- Changing insurance coverage (does your doctor participate?)
- Direct to the consumer advertising

More on the doctor/patient relationship

- Better informed patients with higher expectations (patient satisfaction)
- Large group practices with alternating night and day coverage
- Generational differences in practicing physicians
- Testing rather than laying on of hands/physical Dx
- Difficulties in scheduling to see a new doctor and payment/insurance/paper work hassles
- Shortage of primary care physicians (boutique docs) and early retirement

The Future—my personal predictions

- Healthcare Reform—going no where fast, but ultimately a **universal single payor system (socialized insurance like the VA or Medicare)** like all other developed countries; it may have two or three tiers. (Basic +)
- Hospitals as major players—most with a Staff Model structure like the Cleveland or Mayo Clinic with population based model/capitation/bundling/precision medicine
- Artificial intelligence and declining need for physicians—physicians as technicians
- A rational approach to end of life and palliative care that carry serious ethical issues like rationing, assisted suicide, population medicine, and how much is one year of life worth to society