O. O. M. H.

By

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PROLOGUE

This paper will be a totally new departure for me. In the past, my papers have been done in the classic scientific way, with research of the literature, followed by painstaking note cards containing the data, assembling the data, and finally writing the paper. In this type of paper, one can defend their viewpoint by falling back on the sources used. This paper is solely my viewpoint. The only source is from my experience and, if you choose you may take issue with anything presented.

This paper deals with health care delivery. At this point I might expect to hear a yawn from the audiance, but before you do remember that health care is where a very large chunk of our dollar goes. The paper is basically divided into three sections which I have entitled "THEN, NOW, and LATER." I shall discuss health care delivery beginning with the doctor, his medical education, his practice of medicine (health care delivery) and then we shall talk about the economics involved. As we go through the various stages of history we shall see a vast change in how one has gone about obtaining and receiving medical care. The final section entitled "LATER" deals with what I project to be the future of health care delivery. You may notice from time to time, certain resemblances to your own changing occupational practices. With this in mind let me proceed.

THEN (B.B.C.)

The era that I refer to as "THEN" goes back as far as hippocrates and probably ends with the 20th century. The doctor, as an individual, came from various and assorted backgrounds. His motivation to be a physician was probably

much the same as physicians of today. He might have a desire to have an occupation whereby he would meet with people, and by virtue of whatever skill he might have, help diagnose and/or treat the ills that befell man (collective pronoun). His motivation might have been monetary, or might have been totally altruistic. Whatever, in this age of "THEN", an individual had to obtain his medical education primarily from another individual and thus he proceeded to serve an apprenticeship in the art and practice of medicine with someone who was already "trained" in practice. There were no specific degrees and no standardized forms of medical education. One simply studied with a man who saw patients, and saw how he dealt with them. What he used and gleaned from this information was what worked and what didn't, how to react, and not to react to patients, and their family; how to react and not to react socially with patients and their families, etc. This was the "art" of medicine; is it lost?

Thus, the early physician spent much of his time interacting with the individual. This came about as a matter of course simply because the number of medications he had to use were few and not very efficacious. In this period, the doctor was expected to be more mobile than the patient, and while in some instances the patient was brought to the physician for healing, in most cases the physician made what was referred to as "house calls."

Even into the early 1900's specialists were expected to go to their patients rather than vice versa. Physician's time was not spent as much in medicating the patient or operating on the patient as medications and surgery did not lead to a significantly high percentage of recovery until after the 1900's.

The cost of training varied with the individual with whom the practitioner studied. It was a common practice even up into my grandfather's time. I recall that there was a particular surgeon that my grandfather wished to study "under", but this was not possible as my grandfather could not afford the $10,000 fee for a two to three year apprenticeship.

In this age the teacher was held sacred and hence the section of the Hippocratic Oath stating "to reckon him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it." Also, it was required that physicians pass on information. This also is in the Hippocratic Oath "I will impart a knowledge of the art to disciples bound by a stipulation and oath, according to the law of medicine, but to none others."

Physicians and surgeons at one point were barbers. In this period of "THEN", the type of individual who went in medicine was anything but "upper class." Medicine was not a prestige field. The length of training was totally variable depending on what the individual felt he needed and what the teacher felt he must demand.

Even after the beginning of medical schools, the time involved varied somewhat and the selection of students was limited only to those who could walk in off the street and pay the "freight." The loss of time involved in training was not great. (I would like to think that perhaps this is one reason for the increased cost of health care delivery today.) In the "THEN" of long ago the doctor had no need for specialized training; there was none and he was expected to do it all (medicine, surgery, etc). However, by his reputation, he might have become better known for one particular type of healing than another, and I am sure attracted patients with these particular problems.

There were no third party payers. The fee was not set by an insurance company or the California Relative Value Scale, it was the fee that the physician thought was "suitable." It was often negotiable and generally was tailored to the patient's means. This pricing practice occurred even up until the last 50 years. My grandfather's ledger books showed on two separate days gall bladder operations. On the first gall bladder operation he charged a pig. On the second gall bladder operation he charged $5,000. This was a fee even large by today's standard. I asked him about this and he noted that the first gall bladder belonged to a farmer who was having trouble making ends meet but had a lot of pigs. The second operation was on a wealthy individual who had sent a private train to bring him to the place of the operation. He performed the operation, stayed several days postop watching the patient and then rode the private train back. This accounted for about four to five days time. It was felt that the difference in fee was tailored to fit the payor. This was the way it was in "THEN", B.C.C. (Before Blue Cross).

If you will remember my paper on Revolutionary War Medicine you will remember that the fees then, viewed from today's position, were probably equal despite the fact that the training was less. I mentioned a particular physician who agreed to take care of a family for their "natural" lives for 1,000 acres of land. This offer is still good and I shall make it to anyone at anytime. The "THEN", B.B.C. did not dend abruptly, it ended somewhere between the mid 1800's and the early 1900's, and at this time, there were changes in health care delivery which were to have a lasting mark on the future of medical care. This brings us up to the period I call "NOW."

NOW (B.D.R.G.)

The "NOW" type of health care delivery, the physician is expected to spend longer periods of training (usually a 4-year period of college followed by 4 years of medical school, followed by one year of internship and then a variable period of residency

from 3-7 years depending upon the specialty and the time involved may be between 9 and 15 years of post highschool education). Currently, the cost of a medical school education is running up to a figure approaching $20,000 a year for tuition alone. It becomes rather easy to see that if a physician finishes medical school with a debt somewhere in the neighborhood of $100,000 plus and then has a three to ten year period of additional training that is reimbursed at or near the minimum wage, eventually such an individual will begin the practice of medicine and have to include, in his costs, some monies necessary for debt service.

"Now", the patient is expected to be more mobile than the physician, and the physician, since he is caring for more patients, generally stays in a more centralized location (office or hospital) and primarily sees and treats his patient there. Another reason for the change in the physician's mobility, is that with the instrumentation now required for more accurate, and rapid, diagnostic approach, the equipment is not mobile and the physician must stay where he is surrounded by the necessary paraphernalia.

The cost of medical care, which, in the previous age was directly borne by the individual, is now (in the main) shunted through some third party payor i.e., Blue Cross, Blue Shield, Medicare, Aetna, etc. The individual and/or his employer may contribute toward the individual's health care, and in this arrangement, the individual often loses site of the fact that he is still the "payor." If the employer has to include the cost of medical care in his overhead, then the cost of his items or service is raised to reflect that cost thus causing others to bring their cost and/or services in line based upon his effect on their businesses. The cost of medical care is ever increasing because of, (1) increasing numbers of people that are demanding top grade health care with all the extras, and (2) increasing technology producing new diagnostic and

treatment modalities.

In contrasting the "NOW" age with the previous one "THEN", the individual did not become a patient as willingly. It was recognized that the patient and physician were busy and to occupy either the physician or patient's time over minimal matters was generally not done for several reasons; (1) The physician often could only help relieve suffering and was generally not able to cure the condition; (2) Many conditions were recognized by the patient to be such that the patient knew he would either get well or die and that the physician's intervention probably would not alter this a great deal. Not the least of the spirit of reluctance of individuals to submit themselves to treatment, was the nature of the treatments themselves. If you will recall such fascinating therapy as blistering, leaching, or administering a clyster (5 liter enema) were acceptable. These probably were not looked upon with any spirit of happy anticipation. Nevertheless, we probably do essentially the same in different formats to people and patients seem to tolerate it better. If any of you have had preparation before performance of total colonoscopy you realize that people do suffer indignities yet. We have more procedures (things) we can do (perform) on patients today. Most of our procedures are associated with either diagnosing conditions and/or treating disorders. Thus, we can arrive at a more rapid knowledge of what the situation is and, if nothing else, determine whether or not a patient is going to get well and what other forms of therapy may be necessary.

We are more prone today to seek medical care probably because we feel we prepaid for our medical services, and that this debt is owed us for our monthly payment to our third party. One problem that physicians face, is that when the service is rendered, the patient sometimes forgets that his payor (the third party) has an individual agreement with him (the patient) and that this agreement may not cover the

particular problem that the he has. It may not cover it at all, or may cover only a portion of it depending on the contractural agreement. When the third party does not pay for this the patient sometimes misconstrues this as the physician's fault and feels it was due to the physician not putting the right words in the right spaces on the insurance form.

This is the sort of health care financing problem we face, since the patient often sees several physicians, his generalist and multiple specialists for any sort of significant medical problem and numerous forms are required to go to each. Patients today almost need a virtual medical shopping center. This is the way our hospitals have grown.

At this time, we are not only paying for our current medical care, but our paychecks are being snipped off little by little to help defray our cost of medical expenses when we get older (Medicare). In the previous age of "THEN", the family was expected to provide for the health care of relatives and one used whatever retirement funds he might have to help fund any medical illness in later life. Today, our civilization has evolved to the point, where the money is taken from us in our working years and then allocated for our future health problems. The only problem with this is that no one knows to project with any degree of certainty what the cost of care is going to be. Twenty years ago, no one could have envisioned that coronary artery bypass surgery, CAT scans, etc., would be performed as regularly as they are, nor would we have anticipated the increasing cost of medical care which have occurred; (1) By the natural process of increased cost of living; (2) The increased cost of equipment and cost of doing business, and (3) The increased demands on the part of the patient to receive the ultimate in today's medicine. This has lead us to the point that it is now known that in 1988

Medicare will be bankrupt. One problem is simply that we live too long. Unfortunately, this problem is going to be compounded in that it is now projected that our children will live to be even 10 years longer than we do. You will notice that I titled the section "NOW", B.D.R.G. This set of initials is before DRG's (Diagnostic Related Groups). This is what we are facing today.

LATER (N.L.O.)

Nostrodomus Look Out

Let us look into the future of health care delivery. Start with the doctor. He will become more and more immobile. He will be primarily based in an institution that will have the equipment that is necessary for him to perform his function. It appears that what we call noninvasive tests (those that are not characterized by sticking things in patients) are going to be the main stay of diagnostic medicine. The latest on the horizon is the nuclear magnetic resonator which is another way of taking pictures inside the body. We have evolved from x-ray to sonography to computerized axial tomography and now into nuclear magnetic resonance. I would envision that there are other means yet to be discovered whereby the physician can see inside the body without putting dye or using surgical techniques to inject various body cavities. By these techniques, more and more of our diagnostic medicine will be performed as an out-patient. This will take less of the patient's time and will also cause a decrease in the number of hospital admissions. More and more diagnostic procedures will be done as out-patient and therefore treatment will be able to be rendered without hospitalization.

The coming aga of computers has already altered many of our diagnostic tests. The computerized axial tomogram is one such application. X-rays are combined by the computer and enhanced for better visualization. I see applications in the

future almost beyond comprehension. A few of these are: (1) An application that has been described for years but has never been done with any widespread adherence. This is a centralized patient data based system. The way I see this working is there would be a central computer in all data that is collected on the patient during his lifetime is entered. New data replaces the old data. This has to do with the new information regarding patient history and laboratory data. This would enable a physician or hospital to instantaneously obtain information on a patient. However, this would have to be protected data, so that the individual requesting the information would have to have a "key" to unlock this confidential material. This is certainly capable of being done now. The need for this service in our highly mobilized lifestyle is easily recognizable.

When a patient transfers from one doctor's care to another there would be no need to transfer any charts, etc., only the "key" necessary to unlock that patient's data. Since many patients are "lost to follow-up" and don't return for care the physician may be able to find these individuals and make sure they get proper care.

Another application which seems immediately useable is storage of information regarding drug reactions. We know what some 2 drug combinations can do. In some instances the addition of a drug may increase or decrease the metabolic rate of the first drug and thereby create higher or lower levels of drug within the body. We are gradually learning what these combinations are. We don't have any idea what three, four, or five drugs in combination will do. The computer will help us keep track of these interactions and warn the physician of such interactions and also give information regarding what one might do when adding a second drug.

Surgery is changing with new techniques even into the cutting of tissues with lasers. Guidance of exploratory probs and cutting is being done with computerized axial tomography. With the coming of mechanical staplers we find larger portions of surgery can be done in shorter lengths of time. The monitoring of vital parameters is increasing such that the patient can now have numerous parameters covered with one bedside monitor. With all these new techniques of course means increased costs.

The physician's training may take one or two courses. My crystal ball is foggy in this. One thing that seems evident is that the cost of medical education will continue to rise. Suppose a wise physician uses his skill to expeditiously and economically arrive at the patient's problem and treatment. If this is done, then the only way to further cut costs is to either decrease the services available or decrease the population to which the services are presented. We are at the point where we cannot provide everything for everybody. Say a particular mode of therapy (artificial heart valve replacement for a 90-year old) can be done, doesn't necessarily mean it should be done. Cost accounting is creeping more and more into the delivery of health care and I see this as being ever increasing spector on our horizon. Hospitals and physicians are going to be made more and more accountable for procedures and hospitalizations. It may come to the point where we will have to show statistically that what we do is going to either increase the patient's life or make his life significantly more worthwhile.

Another way to help cut medical costs is to save money on the younger population. Two classes of physicians could be provided such as we see in Russia. They call the one who primarily encounters the patient a feldshare. This is basically a medical technician. The U.S. government now uses technicians who follow algorithms to treat specific problems. An example

of this is suppose you have a patient with a chief complaint of sore throat: the medical tenchician would follow his algorithm and by history narrow the possibilities down to either viral pharyngitis or streptococcal pharyngitis. At that point a throat culture would be done and based on the throat culture antibiotic given. A physician would only enter the picture if the patient did not respond to treatment or if he had some complication from treatment that fell outside the technician's algorithm. This same approach could be handled probably by computer without even the technician being necessary.

I see no change in the cost of physician's expense and education generally. The time involved for fully trained physicians will not become any less. Since this is the case and since there is a rising cost of medical education, the day is probably upon us when virtually no one will be able to provide for their own medical education. At this point, unfortunately, governmental support for medical education with subsidization of a medical education will be necessary. This is not what I want but what seems to be a logically extension of the circumstances at hand. It is certainly conceivable that dispensal of medical care will be at the hands of uninformed medical service.

As to who is going to pay for health care delivery it would appear that there are basically two classes of payors: (1) Those who are working and contribute a portion of their income and (2) The employers who likewise contribute some. There is a large group that we see who are retired and have contributed in some form to their medical care.

We now have another ever increasing group dealing with health care delivery which add their cost to the overall figure. I shall call this group the overseers. Since the cost of

medical expenditures are greater than the number of dollars coming in, our government in its wisdom, has said that one of the problems must be over-utilization of these services by patients and physicians. Thus, a group of overseers (Peer Review Organizations, etc.) have been called upon to see that these services are not over-utilized. Thus, the time has come when the physicians had to have prior approval for hospitalization before the patient can be admitted. At this point authorization only deals with nonemergent conditions. However, if enough money is not saved with this maneuver, it would certainly seem that emergency admissions will probably pass by the eyes of the same overseer. Big Brother is truly watching over us.

In order to further save money on health care delivery the recent trend has started to pay for Medicare and Medicaid patients on a fixed dollar basis. In other words, now depending upon the final diagnosis, the patient's hospitalization will have affixed to it a certain number which reflects the DRG (Diagnostic Related Group). The federal government expects to pay for a heart attack with "X" number of dollars. If it happens to be one that is extremely complex and causes significant longer hospitalization, the hospital will have to absorb that financial loss. It is felt that in the long-run things will equal out. This is going on now. Certainly if this, and the other measures, does not save enough then the next step will be (and already have been brought up) one of several things: (1) Requiring the physician to accept the dollar figure that the federal government pays and (2) Controlling out-patient cost as well. What I have just said when applied to your particular occupation can amount to the following: You have just been told who your clients will be, what you must do for them, and how much you will receive for performing your service or selling your goods. This is all without any knowledge on the part of the payor as to your costs or what

your supplies run, the salaries necessary in your area are, etc.

I know no one has asked but I am going to tell you anyway, how I would like to see medicine practiced. I see a basic need for the family practitioner or someone to serve as the patient advocate and guide to the health care maze. This should be someone who knows the individual's personality traits, family and job pressures, etc. A computer could probably gather the data but would not really know these parameters wall enough to give the individual attention. A concerned individual needs to meet with patient to decide what information should and should not be put in his computer file. With this in mind, the person who interacts with the patient and knows him best should be the one to interpret medical information to him. Much of the care today and in the future is going to be rendered by an individual specialized in medicine in various fields but one central individual should be at the hub of this method of health care delivery to explain the technology and language the patient and patient's family can understand.

I feel that indigent medical care is the responsibility of the community primarily not the state and not the federal government. I don't think this will be accomplished but is the way I feel. We are going to have to as a medical community decide on levels of preventive health care. We need to band together and decide what is a standard for health care. We have to realize that there are levels of health care. We have to realize that there are levels of health care, what is felt to be basic necessity for continued medical care and the form of periodic medical evaluations and what is the epitome of medical care are two different things and certainly will have different price tags and may not be available nor desirable to everyone. We have given up group medical care. Hospitals no longer have wards where indigent patients would be treated with

perhaps less private care but nevertheless, the same medical care as others. I know of no physician who changes his medical care approach based on the patient's pocketbook. We have to be more and more aware of what the patient's ability when prescribing medicines however. Patients are not all the same. Seriously take a look at the restraints put on us with the cost of overseers and see if they indeed are worth their dollar figure or are they just denying further medical care to some individuals.

Some of the above may have sounded pessimistic. This is not the way I feel. Medicine to me is one of the most rewarding experiences that I have every enjoyed. I would make no change in what I have done. Nevertheless, I do wish that I were more free to care for the patient than I am at the moment and I do resent government intervention into this process. For this reason, this paper has been some catharsis for me. Like thumbing ones nose at the establishment even though unfortunately people responsible are not in the audiance. I started to entitle this paper as "Move Over Uncle You Are In My Way" but settled on simply the title "Out Of My Head." This is quite often the way I feel when encountering further and further, and deeper and deeper piles of medical forms. Some day life may be simplified and all of what is worthwhile to be known about you will be contained on floppy disc by you bank, your physician and the IRS.