

**Under Managed Care We Cannot Now, Nor Ever Will,
Approach the Quality of Care We Were Taught to Deliver**

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F. Joseph Flatley, was born in Greenwich, NY, and received his Bachelor of Arts degree from Colgate University before matriculating into the Class of 1954. Following two years of postgraduate training in Internal Medicine at Ohio State University Medical Center, he served for two and a half years as a US Army medical officer at Walter Reed Army Institute of Research, then underwent further training in cardiology at Strong Memorial Hospital. For 36 years until retirement as Clinical Professor of Medicine in 1996, he practiced internal medicine and cardiology in Rochester in private practice and as a member of the clinical faculty of the medical school at Strong Memorial Hospital. His teaching of medical students and house officers twice earned him distinguished teaching awards from the School of Medicine and the Department of Medicine of Strong Memorial Hospital. His activities in local, state and national medical societies include serving as President of the New York State Affiliate of the American Heart Association, President of the Rochester Academy of Medicine, and as a member of the Board of Overseers of the University of Rochester School of Medicine and Dentistry. In retirement as Clinical Professor of Medicine Emeritus, he continues clinical teaching of students and house officers on a part-time basis.

I vividly remember our first day of Medical School and Dean George Whipple's admonitions. These were "You will dress and act like ladies and gentlemen because you are passing through the hospital and on public display when going to class" and, "DO NOT SKI." I had heard that in prior years he had added a caveat, "Do not marry in medical school." However, one half of our class was made up of returning veterans who were already married and many were parents; therefore the subject of marriage was not mentioned to us.

In the winter of 1959, Roger Boulay, a medical resident and skiing enthusiast, organized a ski day at Bristol Mountain. As a result, a pediatric resident appeared for duty in the Emergency Department (ED) on crutches and in a leg cast. Roger, another resident in medicine, and an ED nurse were all limping badly from various injuries incurred that day while skiing or at an after-ski party. Seeing these, a lady who had brought her infant into ED for care inquired of the ED secretary, "Is this the hospital for crippled doctors?" Dean Whipple should have ordered that residents could not ski either.

After more than 2 years as an Army medical officer, a senior medical resident and a year of cardiology fellowship, I entered practice in 1960. For \$3000.00 I purchased all the office equipment and a small cadre of patients acquired by a former chief resident who had moved to a Group Practice in Ohio. Many of those patients as well as their children and their children's children were with me upon my retirement in July 1996, and they continue with the successor to my practice.

Although I did some medical consulting for several local corporations over the years, my practice was largely general internal medicine with associated teaching of medical students and residents in the hospital and the office.

The fervent joy and the enduring gratification of practice were the close, multifaceted professional relationship, I was privileged to have with each patient. Some patients are especially remembered:

- The patient who came to me my first day of practice and whose baby I had delivered as a third-year medical student seven years previously. She remained as my patient until I retired as did over 30 members of her family.
- The patient whom I followed as a resident in the neurology clinic after she had previously been told by a neurosurgeon that she had multiple sclerosis. She called me to make a house call my first day of practice because she felt she could not arise from bed. She had been admitted to the hospital 3-4 times per year over the prior four years for similar complaints. I supported her psychosomatic disorder with regular office visits, occasional placebos and anti-depressants. She has remained fully functional and was not hospitalized again for over 20 years until she developed acute diverticulitis.
- The 19-year-old patient admitted to the hospital for severe headache and vomiting of one week's duration. The intern had ordered skull films, a CT scan, a lumbar puncture and multiple metabolic tests. Sitting with her and taking an extensive history, I discovered that her symptoms had begun one week earlier immediately after she had learned that a priest who had counseled her extensively had suffered a heart attack. She had overwhelming fears of death and loss related to an experience with her grandmother when she was an adolescent. By chance I had seen the priest's name as a patient on another hospital floor. He was recovering well. I brought him to my patient's room, and miraculously her symptoms disappeared - without the X-rays and lab tests.
- The man with gastrointestinal hemorrhage whom I had seen on a house call. He demonstrated the stigmata of pseudoxanthoma elasticum and required subtotal gastrectomy for control of bleeding, which was due to this underlying genetic disease.

These are but a few of the challenging, exciting and fulfilling experiences I have had in practice. Each of us can recount hundreds more.

Our medical school class had the opportunity to experience the wisdom of many of the giants in medicine as each neared the end of his career - Drs. Whipple, Wilson, Morton, Bloor, Tobin, Adolph, Fenn, McCann, Bradford and many others. I believe the professional lives of all of us were enriched by the teaching of Dr. John Romano and Dr. George Engel, whose emphasis on the psychosocial factors in relationship to health and disease enhanced our ability to see patients holistically long before the term became popular. Their emphasis on the importance of talking to patients not only about their symptoms but also about the setting in which their symptoms occurred, and their emphasis on evaluating the patient's overall psychic milieu were instrumental in aiding us in understanding patients better and thereby improving our ability to care for them. By utilizing this approach we automatically became more empathetic and more capable physicians.

With the education, rigorous training and dedication we received in medical school and residency, we delivered Total Quality Management (TQM) long before the term became fashionable in U.S. industry over the past 25 years. Our single objective was to provide the best, simplest, most direct and economical care for our patients. Our patients responded to this approach with loyalty and trust.

Unfortunately, another type of management has overtaken the providers of medical care. This is called "Managed Care" as exemplified by "Health Maintenance Organizations." The purpose of Managed Care is to control cost. Physician reimbursement is decreased. Specialty referral is limited. Physicians are discouraged from spending time with patients and "car-wash" medicine is encouraged. Medicare reimbursement for primary care has been sharply decreased despite promises to the contrary.

The HMO "sales pitch" is that quality medical care will result from following algorithms and guidelines fashioned from "evidence-based medicine." Cookbook, computer-based, time-limited managed care medicine will never approach the quality of care delivered by caring personal physicians who sought out, knew and respected the whole patient including the relationship of patient's psychological needs to his her disease states. The HMO approach has all the objective data, numbers and percentages relating to many disease states, but that is only one-half the equation and one-half the information needed to properly treat a patient. Managed care discourages the physician from spending the time required to learn what the patient is feeling and thinking; therefore medical judgments are made on a generic basis that do not reflect the impact of the presence of disease and its treatment on the individual patient's emotional equilibrium. In addition, the threat of frivolous litigation encumbers a physician's judgment, and the insertion of managed care between patients and physicians only amplifies this encumbrance.

We were taught the philosophy of TQM in medical school (but not by its current name) and practiced with TQM as our basic tenet for 40 years. **Under managed care we cannot now, nor ever will, approach the quality of care we were taught to deliver.** Physicians will do wonderfully well as far as "cookbook" guidelines care goes, but those guidelines will not elicit appreciation for the patient's feelings, fears, hopes, anxiety, terror, and need for support and comfort. TQM has been eliminated from medical care with the present system - and for that reason I retired before I otherwise would have had to.

I do not have the perfect answer to the present deficiencies in the delivery of medical care. I do know control of costs will be necessary by limiting access to expensive tests and by decreasing specialty procedures. If our politicians ever find the wisdom and fortitude to make the necessary changes, maybe it will be rediscovered that patients improve when allowed to see a physician who is empathetic, who wants to listen and to learn of patients' feelings as well as their symptoms.

If that happens soon, I might be tempted to return to practice.