

What is in the Future for the New Physicians?

Paul O. Simenstad, M.D.

Paul Simenstad was born in St. Paul, MN, and attended Carlton College prior to entering medical school. Following graduation from medical school, he interned in the two year rotating internship at Strong Memorial Hospital and undertook family practice for a year before entering the U.S. Army where he served as Chief of the Outpatient Department at Fort Leavenworth, KS, for one of two years of active duty. He joined the multispecialty Dean Clinic of Madison, WI, in the Department of Internal Medicine and subsequently served for thirteen years as Medical Director of the Dean Health Maintenance Organization. He currently volunteers as physician in the Free Clinic in Madison and serves as the Chairman of its Advisory Board. His experiences have led him to advocate staff-model HMOs over fee-for-service practice models.

One of the most surprising statements our generation of physicians hears from colleagues is ‘I don’t want my children to go into medicine.’ Despite this, medical school applications are higher now than ever. Don’t the young get the message from older physicians? Are they still as idealistic as the generation which entered the University of Rochester School of Medicine and Dentistry in 1950? Then, we wrote short essays on why we wanted to become physicians. Today’s applicants probably give the same persuasive reasons to gain admission. Will they be sorry about their decision because of managed care, for-profit hospitals, aggressive drug companies, physician hospital organizations (PHOs), Physician Practice Management Companies (PPMCs), Medicare and Medicaid fee reductions, and having to accept reimbursement through capitation? I am optimistic that the great majority will be thrilled with their good fortune to be either practicing physicians (or research physicians), and will do just fine in managed care or its successor. The practicing physician will have new challenges, and also very great opportunities. Were the good old days better when we practiced medicine with no one looking over our shoulders through computer-assisted quality programs, patient satisfaction reports, and utilization comparisons with other doctors and hospitals?

I have had two experiences which influenced my thinking about the changing roles for new physicians. I practiced in a multispecialty clinic and helped form an HMO. Perhaps these mid-western medical experiences have given me a different concept of medical practice than many of my medical school classmates. I was an internist in a multispecialty clinic, which grew from 19 to 350 doctors scattered in 20 sites. The patient had only one clinical record. My partners could see how I practiced medicine because all lab and x-ray reports, problem lists, previous hospital summaries, and operative reports were in the same chart. We had monthly meetings of our department and clinic-wide business meetings. We were continually doing case-by-case “peer review” because of the shared record, and we discussed whether a new physician would be a good “group” doctor. Clinic income was divided by a formula which included production, equality, and seniority criteria. We were in charge of our destiny. It may be more difficult for new physicians to control their futures. In order to do this now; they have to prepare themselves for a changing role because of the big non-physician players. Medicine is no longer a “cottage industry.” But, physicians have great power to influence even these big players, if they work together. Seventy percent of all health care costs are controlled by the physicians. Physicians are the only ones who can keep costs down and yet improve the quality of care through “best practices.”

The second mid-western experience for me was the coming of managed care. Before managed care, I had been on the county medical society Fee Review Committee and was asked to be the advisor to our local Blue Shield company. For the first time, I saw fellow physicians “upcoding,” and in other ways “gaming” the fee-for-service system. When I would ask for the operative notes and patient records, I occasionally would find sloppiness, inaccuracies, and a huge difference in the care given by comparable physicians and hospitals for the same diagnoses.

In 1983, a staff-model HMO moved to our city, Madison, WI, was set up like the Group Health Clinics in Seattle and Minneapolis. This was a wake-up call for our clinic, which by then had 80 doctors. We had to make a decision. We could join a managed care program under the auspices of a large insurer like Blue Cross and Blue Shield, or we could start our own HMO, which we did. The HMO originally was small so we could continue in full-time practice, which is important for a realistic perspective. As time went on, we saw that managed care could reduce costs for our employer purchasers of health care. Care could be more efficiently organized using methods such as employing nurses as case managers, encouraging appropriate hospital lengths of stay, establishing a drug formulary, and making appropriate and timely referrals to the multispecialty clinic. We could keep our HMO overhead at about 7%. The HMO has prospered and also has Medicare and Medicaid programs.

Our hospital now is a minority owner in our HMO, and we think we are strategically and financially stronger. Financial strength has been the Achilles heel of physician organizations. Physician groups generally have not been careful to set aside profits and acquire capital for projects like out-patient surgical centers, clinic pharmacies, outpatient rehabilitation units, and participation in managed care organizations. Obviously, the recent University of Rochester-trained physicians may love patient care and be less interested in finding business partners who can bring in capital and business efficiency, but there will be those who can practice medicine and also serve as spokesmen for the profession and patients. I firmly believe physicians should be strong believers and that, as a group, we can contribute greatly to organizing the best medical care for our patients. Not only do we have to continue the “revolutionary” idea of listening to the patients for their medical complaints as Dr. Engel and Dr. Romano told us in the 1950s, but we also have to listen to them regarding their wishes to be informed about choices for a health plan and choices for treatment for their illnesses. We also have to listen to our fellow physicians, and to our fellow hospital administrators, managed care executives, and clinic administrators. We have to give them the very important pro-patient message. The new physicians coming into practice in 1998 may be fortunate to have the possibility of managing their clinics and HMOs as we did. It is more likely they will have to partner with others of whom can be so concerned about the bottom line that they can be heavy-handed. However, in most medical “market areas”, physicians can join good organizations and be surprisingly effective. They must seek key seats at the administrative table in their organizations. In any system, they should encourage the use of information which leads to the best patient care and discourages costly and worthless medical treatments. To do this, computer data is needed. The computer analysis of patient care can be a wonderful tool for the new graduates of the University of Rochester just like the newest lab test or medical imaging study.

As a result of my experience, I hope the new physicians who graduate from the University of Rochester School of Medicine and Dentistry will enjoy practicing medicine first and foremost. But, I hope they also will not be reticent to use their prestige and ability in health care administration so they can continually offer the best patient care possible no matter where they practice.

