

Editor's Note:

An excerpt from this interview between Harold Hedges, M.D. '58 was featured in the Spring/Summer issue of University of Arkansas Medicine, the College of Medicine magazine. We think alumni and students alike will enjoy reading more of this intergenerational discussion.

Then and Now

When Harold Hedges, M.D. '58, entered private practice in 1963, an office visit cost \$5. A house call? Just \$10. Times have changed, but not Hedges – he's still in practice, providing primary care to central Arkansas and thriving on building relationships with his patients. As fourth-year medical student Mary Burgess prepared to enter training and practice in internal medicine, she joined Hedges for a cup of coffee to talk about the changes in medical school, the challenges facing physicians today and how medicine has evolved.

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HH: When I started medical school, we had a class of 96 students. There were just four or five women in my class. Right now in medical school I think it's almost 50-50.

MB: We started out with a class of 150 and I think it's about half and half. What about your hours in medical school as a student?

HH: We didn't get very much sleep! The first year, it was study, study, study. We would go to school and be in lecture and labs all day. We were there from 8 to 5, and then we would all go get something to eat. There was a group of about six of us that studied together almost the whole time. It really helped us get through medical school. And once we got into clinics, we were there all day long and the hospital too. When we were on call in the hospital, we stayed all night.

MB: When I was a first-year medical student, we were introduced to patient care and what they call standardized patients. We had more of that in our second year and we were able to see a few patients in the hospital and then in our third year, we started clinical training. Was it similar for you?

HH: Our first year was strictly biochemistry, anatomy, neuroanatomy and physiology. I remember limited contact with patients that first year. I worked part time at a hospital when I was in medical school with no formal training. It's one of those things you learn on the job. My very first job was sharpening needles, because all the needles were re-used at that time. Hah! That was a long time ago.

MB: When did you finally get patient contact?

HH: We started a little bit in our second year but in our third year we really started seeing patients. We were in hospitals the third year and then in our fourth year, we did more in clinics. So that was our introduction to that. How did you decide on internal medicine?

MB: I liked both the surgical and the primary care rotations when I did them. But I just felt much more comfortable in primary care and I liked talking to people and developing that relationship. I felt my calling was to do primary care.

HH: You will enjoy that a whole lot. That's the nice thing about internal medicine – the variety that you have in it and the relationships that you get out of it.

MB: Why did you choose family medicine?

HH: When I graduated from medical school, I wanted to do family practice but I was really afraid I didn't know enough. I went into the Navy and became a U.S. Naval Flight Surgeon, and spent two years on the aircraft carrier, USS Saratoga. And then I had a year and half left in the Navy. I became an assistant medical officer at Cecil Field Naval Air Station, a new base in Jacksonville, Fla. and they wanted to develop a family practice clinic. I realized all I needed to know was what my limitations were and where I could get help if I needed it. So that kind of convinced me I could do family practice. I started Little Rock Family Practice in 1963 with a friend of mine [Jim Flack, M.D. '58] when we both got out of the Navy. As a physician, you certainly have to have an inquiring mind and change when medicine changes. You have to have good listening skills. If I have somebody who is really sick today, I'll call them up the next morning and say 'how you doing?'

MB: So you never had any intention of staying in the military to make a career out of it?

HH: No, I gave it some thought. It's one of those things, the higher up you get in the military, the further away you get from patients sometimes. I wasn't interested in the administrative duties. I'd much rather take care of patients than be involved where you have to go to meetings.

MB: The desire to want to be the best at what we're doing is important. If the desire to be the best possible doctor isn't there in the beginning, then it's never going to develop.

HH: I want every patient to get the best medical care that's available. If I think I can't give that to them, I'm ready to call the specialist or somebody who can. It's important to know your own limitations.

MB: You can't know everything.

HH: You can't, and it's rare a patient comes in with one problem. You have to handle all those in a 15 minute office visit.

MB: That's what I love about the heart of medicine. It's not just the textbook learning - it's being able to put it all together.

HH: That's what makes it interesting! It's allowed me to develop personal relationships with patients and make a difference in their lives. I can't imagine retiring and not being able to continue it.

MB: I love hearing a patient's story and making a difference in any way.

HH: Whenever I teach courses in allergy and asthma, I ask them to tell me their story. Not their history, their *story*.

MB: Did they teach you communication skills in medical school like how to do the medical history and physical?

HH: There was a time when we did histories and physicals in groups. We would present cases to each other. And then as far as the hospital, we rounded with the specialists in the morning. We had to be there at about 6:30 a.m. to round. There would be a group of us that followed the internist around and we would all stand around the bed and get asked questions. And the clinic was the same way. We would go see a patient and then present the patient to a preceptor and discuss the patient with the preceptor.

MB: It's still similar but the difference now is that in our first and second year, we work with the standardized patients. We practice communication skills and we're taught good bedside manner. And once we get in our third year, into the clinical years, we work with the attending doctors and residents.

HH: Another thing is we had to do all our own lab work.

MB: Oh yeah, that's a big change too.

HH: We did the CDC, the urinalysis, drew the blood. We did our own spinal tap too – all as students. I delivered about 300 babies during my internship and practice before I quit doing that. When we were interning, a lot of OB/GYN doctors let us deliver babies unless there were complications.

The changes that we've experienced in the field, and I'm talking about specifically family medicine and primary care, is different for each field. One is just the role of family physicians in general. When I first went into practice, there were some family physicians still doing surgery, major surgery – jaw bladder surgery, hernia surgery, delivering babies. We were also doing some minor orthopedic work in the office. We would cast broken arms and treat Colles' fractures. We were doing more orthopedic things than we do right now. We were still delivering some babies and most all family physicians that I remember were doing obstetrics. Then came the evolution of emergency services. When we first went into practice, there were no family practice residencies at the time. We were dealing with rotating internships. The year after we graduated from medical school, we did a year of rotating internships where we took three months of surgery, three months of medicine, three months of OB/GYN, three months of pediatrics. And then we essentially went into practice or into the service.

As an intern [at St. Vincent Hospital in Little Rock, Ark.] we had no emergency training whatsoever. We hadn't even been in the clinic in an emergency room situation more than just observing emergency rooms in medical school. Patients were not using emergency room services like they do now. If I was on medicine or surgery and I was on call for emergency, I might see one or two patients a day. As time went on, St. Vincent asked a group to cover emergency services, so five of us – five family physicians in Little Rock – got together and we gave 24-hour coverage five days a week at the emergency room at St. Vincent. For 15 years, this group worked the emergency room and became the emergency room physicians without any particular training at all. One by one the group started fading after five or 10 years. My group – myself, Dr. Jim Flack, Dr. William Wade and Dr. Robert McGowan – we stayed with it for 15 years. By that time the concept of emergency room physicians was catching on and there were training programs. Until these emergency rooms opened up, we made a lot of house calls. I would make a house call almost every day I left the office. But once emergency rooms opened up and they were open 24 hours a day, it was a lot easier for physicians. That's kind of what happened to house calls. I still make house calls now but not near what we used to make.

MB: Do you think doctors are working the same amount of hours as when you started? If you are making house calls, was it more demanding then?

HH: I don't feel like it was more demanding back then. One thing, we weren't seeing as many patients a day as we see today. I used to think if I saw 20 patients a day then that was adequate. And our overhead was not near what it is today. Our overhead today is one thing that kind of demands that we see more patients. Our overhead when we first started the practice was somewhere around 30 to 35 percent. Now our overhead is 55 to 60 percent of gross target.

When the emergency rooms opened up, we weren't making as many house calls. The volume of emergency services and the people using them began to grow and people got used to not having physicians make house calls, so they migrated to the emergency rooms after 5 o'clock for services. That's what made emergency room services grow so quickly. It wasn't that there were more emergencies but people with runny noses, colds, coughs, fevers and sprained ankles. They used the services instead of waiting until the next day to go to their doctor's office.

MB: The number of uninsured is a big issue right now. Has this always been an issue or has it gotten worse? Because making house calls, certainly they all couldn't have been uninsured?

HH: No, but house calls were only \$10. But of course a \$10 charge then is not what it is now. At that time, it was a significant amount of money. But by and large most people could afford it. There were a number of house calls we made in the poor areas of town that a lot of times we didn't charge them. We did quite a bit of free care away from the office. Probably more than we do now.

Another big issue right now is the evolution of the medical record. In the past, the patient seemed to be the most important thing that I did everyday, now it almost seems like the medical record is the most important thing. Sometimes, it takes me longer to finish the medical record and get it correct than it does to see the patient. Our medical records are just voluminous now. When we first went into practice, we had whole families in a folder. So it would be one folder and four or

five people in it. That didn't last longer than a couple of years before everyone got their own folder. But there is just so much documentation that has to be done. Not only do you document all the positives but also the negatives. If it's not mentioned in your notes, you probably didn't do it or you didn't ask it. The negatives have to be in there. With electronic medical records and all the help that we get with an automatic physical examination, where you can press a button and you have two-pages of a medical exam, you begin to see how these records get to be so large. We get information from specialists and there may be four or five typed pages that they sent a month ago and the only thing that has changed is a few things on the physical. We're supposed to keep up with it. Our charts are getting almost generic. The patient you're describing can lose his or her identification in that medical record.

MB: It loses some of the personal touch.

HH: Exactly. We are big time into medical records. My mother made me take typing in high school and I griped at her a lot because I didn't want to. But I kept with it and now I don't regret taking the class! That to me has been a big surprise.

MB: What has been a positive change in all the years you've been practicing?

HH: Certainly all the new tests we can do. When we opened our office, we had a lab tech and an X-ray tech. There just wasn't that much to do then. We could do a CDC and a urinalysis, a blood-sugar test. We didn't order a lot of tests like we do now. I mean it's a drop in the bucket now. There was no concept of that. Now, we are able to test patients. If they're done for the right reasons at the right time, you can look at almost any part of the body. We used to have nothing like that. We had hands-on medicine and that was about it. About all you could do was use your hands and if you could feel it or listen to it. It's gotten down to what I personally try to do is efficiently and cost-effectively evaluate a patient without ordering more tests than you need.

One of the things that has changed is the number of practices that are solo practices versus groups. When we first went into practice, there were a lot of solo doctors, whether it be surgeons, specialties or family practice. When we started our practice, there were two other practices that had more than one family physician. There were 12 or 15 family physicians in Little Rock, but most were solo. Now, I can't think of anyone. Just the development of these large subspecialty and specialty clinics and the concept of hospitalists have also changed. Year after year, we took care of hospital patients. I would go into the hospital at 6 a.m. and I'd see anywhere from two to 10 hospitalized patients. Then I would go to the clinic at 8 a.m. and work all day and go back to the hospital at 5 or 6 p.m. and see what had transpired that day. It really made more sense for the patient to be in the care of the hospitalists who were there all day long. They could order a test and two hours later, they could read it and follow up in contrast to me seeing them again 12 hours later.

MB: The hospitalist deals with all the acute issues at a hospital that you might not see day to day in a clinic.

HH: Hospitalists also are able to work with social workers and all those ancillary things. They can interact with all these other areas and can get patients out of the hospital more efficiently and

earlier. That's another big change. What do you think the three biggest challenges in medicine are from your standpoint?

MB: I think the rising cost of overhead is a big challenge for doctors. I foresee this will be a challenge especially with my desire to do primary care. Also, covering the uninsured is a challenge not for my particular future practice but for medicine as a whole because of the discrepancy with the working classes, who can't afford health insurance. There is a huge discrepancy in the care they receive. It is being addressed, it might not be properly, but it is certainly a challenge. There's a huge difference in the care you can receive.

HH: I agree. Those are the same things that come to mind. I think the other challenge is getting into disease prevention rather than treating the disease itself, especially with our obese population and our diabetics. Also, smoking cessation and alcoholism. If we could do something about those four things, it would drive the costs of medical care down tremendously. Drug and alcohol programs are big and out there. In our practice, we don't treat much alcoholism or drug problems. I don't see near as much as I used to see.

Another challenge is simply keeping up with the rapid changes in medicine. Not only keeping up with those changes but being open enough and practical enough to make the changes you have to make in your practice when they come along. You cannot be static in medicine anymore. You'd get lost.

Electronic medical records are also a challenge. Especially for the older physicians who may be in their 50s and 60s and don't have a good concept of it. My son is in practice with us and he is a computer whiz. He got us educated in electronic medical records years ago and helped all of us with the transition.

MB: Right, and then one of the challenges is how they integrate individual practices and electronic medical records into a hospital. So that when the patient sees a different physician or specialist or goes to a different hospital, their information can be accessed. We all have our different EMRs in our own clinics and the whole purpose isn't fully being utilized.

HH: It is a big challenge and it's also exciting that it can be done down the road. I bought into it just hook, line and sinker, and I love it. I work out of a BMR. We have a back up chart because we have to. But we've got it so that I can work from home through the office. If there is a situation at the office, they can call me at home and I can access the patient's information and know what to do with it. It saves a lot of time in that way but it doesn't save anytime putting it in. If you don't put the information in, you can't get it out. The EMR slows you down. You can't see as many patients working with it than you can without it. The information you put in is so easy to retrieve. I get as much as I can in on the spot.

MB: With all the challenges ahead, what advice would you give to medical students?

HH: The piece of advice for a future medical student would be to try to get involved in medicine at any level you can. Volunteer at hospital, sign on as an orderly, anything you can do to get involved is important. Getting close to it will help you realize if this is what you want to do.

For present medical students, live as simply and frugally as you can – but comfortably so you don't have enormous debt when you get out. If you can hold that debt down as best you can so that you don't have a big debt it will play into what you can do postgraduate.

My advice to graduating medical students going into practice is when you begin to think about a location, pick the place you want to live and where you want to raise your children. Don't worry about 'I'm needed here or I can make more money here' or anything like that. You go where you want to live and raise your children. That's exactly what I did. I went into it with the idea that I would be here and practice forever. [Dr. Flack and I] made the right decision. We are now a 12-person practice that's been here since 1963.

When you go into practice, plan it on a four-day week. You won't be off on the weekends. You're 'off' but you're busy. Plan for the work of four days so you have a day to give to your families, catch up on stuff you're behind on during the early week. You won't get burned out.

When Dr. Jim Flack and I started the practice, we didn't have a patient in the first week. We'd sit there and stare at each other for several weeks until we started getting patients. As time went on, we really got busy and successful; I was delighted to have a day off. It allows you do something else. This is my 50th year in practice. I'm like the little bunny with the battery on its back. I do need a new battery though! *(laughs)*

MB: For me being in my last year of medical school, the advice I'd give someone who is just entering medical school would be to fully enjoy the experience. Study hard but take breaks when you can. Make breaks. Enjoy things outside medical school. To me, the experience has just been amazing - going through hours of studying together and in the hospital. So many other people don't experience such a unique perspective on humanity.

HH: I think that's great advice. It goes along with working four days a week. Take time out to enjoy life.

MB: That's why I've liked medical school but I've also taken time to enjoy my family at home. If you don't have that balance it's not worth it in the end.

HH: That's what keeps the world going around and around.