

MEDICINE IN CLEVELAND

FROM ELIXIR-FILLED BLACK BAGS TO MODERN MARVELS

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Nearly all men die of their medicines, not of their diseases. So said Moliere, and it was mostly true in the days when David Long became the first doctor to make Cleveland his home in 1810.

The “regular” physicians treated patients with purging through vomiting, laxatives and enemas, bloodletting and blistering, burning the skin with hot plasters to induce pus, all part of the so-called Heroics tradition. Medicinal solutions included mercury, arsenic, opium, and peppermint oil. The main tools of a surgeon were a scalpel, a bone-saw, boiling water, and gauze. Pain was numbed with whiskey.

Today’s “regulars” in medicine have become heroes of a far different sort, and they loom large in both Cleveland’s history and its future. Seismic shifts in the makeup of Cleveland’s economy have made medicine the region’s largest employer and one of its brightest hopes for the region’s successful transition from a city built on steel and autos. Cleveland’s leading healthcare organizations have earned bragging rights to a long list of medical “firsts,” including the first successful defibrillation of a human heart at University Hospitals in 1947 and the first successful coronary artery bypass surgery at the Cleveland Clinic in 1967.

From routine surgeries accomplished through tiny incisions in the belly-button to a face transplant of a woman mauled by a chimpanzee, from a pharmacopeia that spans aspirin to therapy that corrects abnormal genes, from X-rays to detailed, color-coded images of our vascular systems, medicine marches to seemingly endless new awe-inspiring innovation. The average life expectancy of Americans today is about 80, twice what it was in 1850.¹

But still far too many patients die of their medicines. No longer are they victims of their doctors’ lack of knowledge about the mechanisms of human disease, as at the dawn of modern medicine. Preventable medicine and treatment errors claim an estimated 98,000 lives a year nationally; deadly infections that people get in hospitals kill more.

Our cities no longer lose hundreds to outbreaks of typhus or cholera, as they did from poor sanitary conditions as Cleveland’s growth swelled after the Ohio and Erie Canal increased access to the region. Among our modern day epidemics are obesity, diabetes, heart disease, and high blood pressure. Premature death and costly, debilitating

complications like amputations and strokes occur too frequently, even though doctors long ago learned how these conditions can be managed to avoid them.

In America's colonial years, Benjamin Rush, a founding father and Philadelphia physician and important figure in early American medicine, so exuberantly applied his bloodletting "cure" that his front yard buzzed with flies from the blood he spilled. It was only after renowned British journalist William Cobbett declared Rush's work "one of those great discoveries which have contributed to the depopulation of the earth" that Rush's practice waned.² Today, scholars of the history of medicine still debate his place in history because he continued using treatments despite factual evidence that discredited both his theory and his methods.

Too often today, doctors prescribe treatments that overlook what the latest science has determined to provide the most benefit and the least risk to their patients. Chalk it up as an unintended consequence of the breakneck speed of discovery and the way our health care system has evolved: Modern medicine churns out so much new research that it is impossible for any one doctor to stay current. But it is well understood that geographic regions differ greatly in their use of practices that are well established by "science." One reason may be information overload; another is that certain practices become part of an accepted routine of regional peers. Another may be that the way we pay for health care sometimes obstructs our ability to get the best care that modern medicine can deliver, instead of the most.

"Evidence-based medicine' is not just a catch phrase," wrote Dr. Donald Berwick, the so-called father of the movement for safe, high-quality medicine, "it is a promise we want to make to our patients—to use all the care—and only the care—that can help them."

When David Long moved west from New York to become the first doctor to make Cleveland his home, he was 23 and one of the rare practicing physicians to have graduated from a medical school. Only 300 people lived in the area, but a local resident told him that Cleveland's burgeoning growth would provide a good income. He opened a dry goods store and other businesses to supplement visits to sick residents, and he cut his teeth as a surgeon in the war of 1812. Later, he became an active business and civic leader, too.

In the first quarter of the nineteenth century, a doctor's visit cost 50 cents if the patient lived within one mile; twice that if further; the price of a tooth abstraction a dime. There was little that Long and the growing number of physicians really could do for residents who took ill. The germ theory, anesthesia, and penicillin were decades in the future. Competing theories of disease determined treatments, and there were many of both. Homeopathic medicine took root in Cleveland, a school of thought based on the teachings of a German who espoused that disease could be cured by tiny amounts of whatever would cause the same symptoms of the illness. No wonder this approach appealed more to patients than swallowing mercury (a metallic element now known to be toxic) to cleanse the bowels and being relieved of numerous pints of their own blood.

In 1837, as poverty and smallpox plagued the growing Cleveland, the poorhouse was designated as City Hospital. The city was in the throes of a financial crisis, and the new hospital, located next to the Erie Cemetery across from what is now Progressive Field,

soon overflowed with people who had chronic disease, mental illness, or were too poor or old to care for themselves.

The population explosion that came with Cleveland's industrial growth attracted more physicians, and physician-led medical schools. These included a homeopathic medical school, as well as a "regulars" school that was the antecedent of Case Western Reserve University's School of Medicine. By the time the first cannons fired to start the Civil War in 1861, the homeopaths had opened a hospital (evolving into what is now Cleveland Clinic's Huron Hospital in East Cleveland), followed in 1865 by the opening of St. Vincent Charity Hospital, which the first bishop of the Cleveland Catholic Diocese built. Not to be outdone, the Protestants responded by opening their own, eventually taking over a Marine hospital that would later be renamed Lakeside Hospital and evolve into University Hospitals Case Medical Center. By 1887, Lakeside was treating more than 900 patients, each at the high cost of \$1.20 a day.³

Dudley P. Allen was a well-heeled and forward-thinking surgeon, schooled at Oberlin College and Harvard University, a third-generation Cleveland doctor when he returned to the city to build his career in 1883. While he was one of the first to use rubber gloves in surgery, he also was known for making liberal use of his connections to Cleveland's industrial titans to achieve his career goals. Allen was short, brusque, and ambitious, the son-in-law of Louis Severance (grandson of David Long and treasurer of the Rockefeller Standard Oil trust). He had battled his way to the chairmanship of surgery at the medical school and to become chief surgeon when the new Lakeside Hospital opened in 1898 at East Ninth Street and St. Clair Avenue, just up the hill from where the Rock and Roll Hall of Fame sits today.

Allen's political prowess and power was tested when hospital trustees implemented a plan to address the growing need to bring in funds to supplement charitable donations. George W. Crile was 36 years old, handsome and charming and so popular with patients and prolific in his operations that he sometimes was called "The Carver Kid."⁴ Crile and his associates had a prominent and successful medical practice on the west side that catered to well-to-do patients, who trustees hoped would choose Lakeside for surgeries. On their urging, Allen brought Crile on board as an associate.

Almost from the start, Allen and Crile began to bicker. They would engage in years of full-throttled battles for control of surgery, patients, and research space before it became clear that Crile was using his talents and charm to clear the way to succeed Allen as chief surgeon. Neither of them knew that Crile and his colleagues would one day build their own new medical organization, The Cleveland Clinic, and become the chief competitor to University Hospitals Case Medical Center, Lakeside's successor.

For most of the nineteenth century, hospitals primarily were for poor, sick patients. Private physicians collected fees for prescriptions; hospital dispensaries did not. Still, poor people were invaluable for training new physicians, and hospitals were, after all, charitable organizations. As for the middle-class, hospitals were places that were to be assiduously avoided, because of the associated poverty, as well as the non-trivial risk that they could die from infection. Penicillin wasn't discovered until 1928, and it took nearly 20 years more to figure out how to produce it in large quantities (the first large batch in

the United States was produced just in time to supply troops for the 1944 Normandy invasion.) As rubber gloves and other antiseptic measures became accepted and chloroform and nitrous oxide became routine anesthesia, hospitals increasingly became more accepted by the non-poor. As the new century began, hospitals asked more patients to pay, but doctors did not receive the fees. Arrangements were negotiated, such as private wards for their own patients, where doctors could charge fees.

By 1900, Cleveland had 16 hospitals. City Hospital, the precursor of MetroHealth, in 1899 had built a new facility to replace the poorhouse. A new homeopathic hospital that evolved into Huron Hospital in East Cleveland was built in 1879 to accommodate homeopathic doctors, which the “regulars” wouldn’t accept.

A breakthrough study published in 1910 on the state of physician education and training that became widely known as The Flexner Report would spur more. Commissioned by the Carnegie Foundation, the report decried the commercialization of medical education, low admission standards, and the harm being done to patients because of poorly trained doctors.

It is a singular fact that the organization of medical education in this country has hitherto been such as not only to commercialize the process itself, but also to obscure in the minds of the public any discrimination between the well trained physician and the physician who has had no adequate training whatsoever. As a rule, Americans, when they avail themselves of the services of a physician, make only the slightest inquiry as to what his previous training and preparation have been.⁵

One hundred years later, American consumers still are largely clueless about their health and health care—a contributor to the state of things today—but we’ll get to that later. The reason that the Flexner Report was so important is that it spurred standards for medical education, including the requirement of a high school diploma and at least two years of college, preferably replete with science classes, and a four-year medical school curriculum at a school that was part of a university or college with good access to clinical facilities. When the report was published, the Homeopathic Medical College that opened in 1849 required a high school diploma or equivalent, but Western Reserve University, at the urging of Dudley Allen, in 1909 became the third medical school in the country to require at least a bachelor’s degree. Western Reserve, whose ties to what is now University Hospitals Case Medical Center were growing, was praised in the report for its modern laboratories, including a new clinical lab at the hospital to link bedside and lab work, a mutually beneficial arrangement the report said schools in Boston, Chicago, and New York might emulate.

The watershed report recommended that commercial medical schools be closed or folded into universities, as well as others that were ill-equipped to teach basic science and provide clinical experiences in nearby hospitals. It succeeded in swiftly raising standards on medical education, but it also affected the diversity of the profession for decades. The medical schools that remained became more expensive and selective, greatly reducing educational and training opportunities for women, African-Americans, and Jews, who were particularly affected in the great immigration periods following World War I.^{6,7}

Hospitals such as Cleveland’s Mt. Sinai Medical Center, which had started as a religious charity to serve the influx of poor and meet their religious observance needs, also

became necessary to train Jewish doctors who could not get internships and residencies at non-Jewish hospitals. The city's first African-American and women's hospitals were established to serve the training needs of minority physicians.

A new emphasis on medical research also began to shape hospitals, in Cleveland and across the country. When Crile took the reins from Allen to become chief surgeon at Lakeside, he declared "a new era" for the hospital, and indeed it was. More physicians were working full-time in the laboratory, and Western Reserve medical students were required to rotate through laboratories. Lakeside and Western Reserve began to consider a unified vision and lasting affiliation, one that would have top clinicians forgo their private medical practice and make research and teaching, rather than strictly patient care, their primary role. University Hospitals Case Medical Center's academic medicine roots were planted.

The casualties of war always bring new opportunities for medical innovation, and World War I was no exception. Crile, who led a medical unit in France with volunteers from the hospital in World War I, returned to Cleveland with a new vision of how health care should be delivered. While known for his interest and accomplishments in medical research, he had seen in war the benefit of working in concert with physicians who were particularly knowledgeable in certain medical disciplines. His friendship with the Mayo brothers, who had developed a group practice of doctors from different medical fields in Rochester, Minnesota, began to take on new significance. Like patients seen in the Minnesota clinic, those in Crile's clinic would pay the clinic, not the doctor who treated them.

In February 1921 the Cleveland Clinic opened for business in a new building on Euclid Avenue. In a speech to 500 physicians, including William J. Mayo, M.D., who visited for the occasion, Crile said the Clinic would pledge at least a quarter of its net income to the Cleveland Clinic Foundation, whose ongoing focus would be research on diseases. Its successors would carry its knowledge and legacy into future generations through fellowships offered to young doctors:

With the rapid advance of medicine to its present-day status in which it evokes the aid of all the natural sciences, an individual is no more able to undertake the more intricate problems alone, without the aid and cooperation of colleagues having special training in each of the various clinical and laboratory branches, than he would be today to make an automobile alone. We have, therefore, created an organization and a building to the end that in making a diagnosis or planning a treatment, the clinician may have at his disposal the advantages of the laboratories of the applied sciences and of colleagues with special training in the various branches of medicine and surgery.

The Clinic doctors continued to bring their patients to local hospitals, including Lakeside Hospital (University Hospitals' precursor). But Lakeside had been unable to interest Crile in forging a relationship between the new clinic and the hospital. The day after an open house that drew 1,500 people to the new clinic on a Sunday, 42 signed on as Clinic patients. The founders decided soon after that their group practice would need its own hospital. When its growth in patients outpaced the beds it was able to add by buying houses and refurbishing them as hospitals, the Clinic opened a modern 184-bed hospital in 1924, the same day Crile officially retired from Lakeside; a new research building was added a few years later.

Fierce competition between University Hospitals Case Medical Center and the Cleveland Clinic has ensued ever since.

At the turn of the twentieth century, doctors didn't make much money, because it was hard to find paying patients. Most patients still were treated in their homes and treatments were limited, so costs were low. But the status of physicians as a dignified profession began to take shape, even before the standardized rigor of medical education made it so. A book that was popular and revised with multiple editions from 1882 to 1922 advised doctors to wear a clean shirt with a clean collar and fashionable clothing. They were advised to follow five "cardinal" duties at each visit: feel the pulse, check the tongue, ask about appetite, sleep, and bowels.⁸ Doctors should post their fees in their office with a sign that priced consultations from \$1 to \$10, so that patients who pay the lowest are pleased but that everyone knows they are "skillful enough to attend ten dollar cases."

After the Flexner Report, the smaller number of medical schools greatly reduced the number of doctors. Between medical advances, greater trust in physicians and fewer doctors, medical care became more costly. Hospitals began to charge those who could afford to pay, and medical bills were taking a bigger bite out of a family's income, reaching about 13% in 1929, when an average urban family's annual income was less than \$2,000.⁹

It was during his family's own financial problems from medical bills that Clevelander John R. Mannix got the idea of "pre-paid" hospital care, while working as a clerk at Mt. Sinai Medical Center.

By 1934, Mannix's efforts had led to the creation of the predecessor of what is now Medical Mutual of Ohio, a not-for-profit organization that became the first to offer health insurance policies to an entire region that was good for groups of hospitals. Launched by a consortium of hospitals to help with operating costs in the Depression, the first policy issued by what was then Blue Cross of Ohio charged subscribers 60 cents a month, which would cover expenses of a three-week stay in the ward of any of 13 hospitals; 15 cents more each month for a room with just two beds. Benefits received for the subscriber fees included bed and board, general nursing care, routine lab tests and x-rays, anesthesia, ordinary drugs, and surgical dressings.¹⁰

In 1938, Cleveland's Blue Cross became the first plan in the United States to pay hospitals based on the cost of care provided to Blue Cross enrollees¹¹—a key feature that would loom large in escalating health care costs in future decades. The money generally moved like this: Employers paid health plan premiums for each worker who signed up. Health plans, in turn, paid hospitals and doctors when they treated one of their members. The hospitals benefited from having a steady source of income and patient volumes, and so gave health plans, and thus employers, discounted prices.

Insurance for doctors' bills didn't come until 1945, when employers got into the act because of stiff competition for workers during World War II. With a government freeze on wages, they could offer more to employees by adding health benefits.¹²

Then came the boom years.

At the start of the 1950s, health care accounted for 4.5% of the Gross National Product. Infections were conquered with penicillin and other new antibiotics, modern anesthesia had replaced ether, and federal tax deductions to companies for health benefits provided to their employees gave more Americans the means to access health care. Cleveland's modern medical infrastructure had firmly established roots and was ready to play its part in modern medicine.

Western Reserve University's School of Medicine had moved to a new building on University Circle in 1924, and in 1925 the new Maternity and Babies' and Children's Hospitals were completed next door. University Hospitals was formed, taking administrative control of the two new hospitals and Lakeside, which would soon close its outdated hospital on East 9th Street and open a modern new one in 1931, alongside them.

The medical staff at City Hospital (now MetroHealth Medical Center) had become affiliated with the medical school, as had Mt. Sinai Medical Center, whose 160-bed hospital built in 1916 on East 105th Street had more than doubled in size. These completed the set of Cleveland academic medical centers through the 20th century.

Other non-teaching hospitals, such as Fairview and Lutheran, had been established in the sprawling Cleveland neighborhoods and suburbs, and larger hospitals distinguished themselves with new nursing schools and other ancillary services.

While the Great Depression and World War II had triggered financial and staffing crises throughout health care and the region, the economic boom that followed produced medical advances and growth at hospitals within University Circle and beyond. Contagious disease and crippling viruses filled hospital beds. Tuberculosis raged in the 1930s; polio became the scourge in the 1940s and '50s. Both became major foci of clinical and research faculty at City Hospital (now MetroHealth), underscoring its important role in public health. The expanding number of medical specialties, discoveries, and advances accelerated in all Cleveland's major hospitals in the decades following the war. To wit:

- MetroHealth pioneered research that established the link between strep throat and rheumatic heart disease, and one of its physicians was awarded the Nobel Prize for research that led to isolating the polio virus.
- The research department at the now defunct St. Luke's Hospital developed the world's first heart-lung machine at St. Vincent's Hospital.
- Cleveland Clinic heart surgeons performed the world's first successful "stopped-heart" surgery, while a pediatric cardiologist accidentally discovered imaging techniques for coronary arteries, ushering in decades of life-prolonging cardiac surgeries, including the first coronary artery bypass surgery at the Clinic in 1967.
- University Hospitals Case Medical Center's Rainbow Babies and Children's launched one of the first centers on cystic fibrosis research and treatment.¹³
- In 1965, when President Lyndon B. Johnson signed the historic legislation creating Medicare and Medicaid, health care growth exploded, as if a match was tossed into a barrel of gasoline.

When Medicare was enacted to provide low-cost health insurance to people age 65 and over, an average man born in 1950 was expected to die by age 66; a woman by age 72.¹⁴ With accelerating medical advances and increased access to care, life expectancies grew rapidly. So did medical costs.

By 1970, the U.S. was spending about \$75 billion, or \$356 per resident, on health care, which accounted for 7.2% of GDP. An estimated 86 percent of Americans had some kind of health insurance, allowing them to pursue virtually any care and treatment they wanted, without feeling the sting of a big bill. Because their employers paid the insurance company, which, in turn, paid the doctors and hospitals, employers and patients had little notion or reason to inquire about the costs of the care received. Likewise, the growing number of drugs produced by pharmaceutical companies cost little or nothing to people with pharmacy coverage.

Cost pressures began to intrude on what seemed to be unlimited expansion of health care services, technology, and life-extending care in the 1970s. Hospitals were changing fast, particularly those affiliated with medical schools and the associated responsibilities of teaching and research.

Cleveland's large teaching hospitals became magnets for specialists and sub-specialists, who brought the latest treatments and most sophisticated medicine for tough cases. Keeping pace with technological innovations required them to acquire the latest in diagnostic and treatment devices, which had to be paid for, whether patients filled their beds or not. The demands for space to accommodate the growing specialization and the cost pressures to draw more patients spurred the large medical centers to their first efforts to offer more routine care in satellite medical offices and outpatient surgical facilities in neighborhoods distant from the city center. They also forged relationships with smaller hospitals that could refer their patients to their flagship medical centers.

As the medical centers pursued research and other advances, each of the large centers began to take on their own character and to become recognized for particular expertise, locally and nationally. For the Clinic, which had performed its first heart transplant in 1968, it was heart disease. For University Hospitals, which had become one of the first hospitals in the country to successfully treat leukemia with bone-marrow transplants, it was cancer and pediatrics at Rainbow. At MetroHealth, which had been owned by Cuyahoga County since 1958, it was trauma and emergency services, burns, rehabilitation, and being the "safety net" for care of the county's poor and uninsured.

By 1983, when LifeFlight's canary-yellow medical helicopters first took flight, the doctors and nurses crouched over gurneys as they raced from the helipad had become symbols of the hero status that the march of medicine had caused patients to confer on their doctors.

Bigger was better, or least a better bet. That was surely the chorus sounded in hospital board rooms across Greater Cleveland as the 20th century began its last decade. Rising health care costs and the 1992 election of President Bill Clinton, who promised health reform, triggered rapid changes in health care markets across the country.

“Managed care” had become the buzzword of the day, a model that made primary care, not specialty care, the centerpiece of the health delivery system. It was a good theory, but it became a code word for cost-cutting, the way most insurance companies implemented it. Health insurance enrollees were required to first see their general practice doctors—pediatricians, general internists and family docs—who would decide whether to refer them to a high-cost specialist. Filling hospital beds promised to get more difficult for the region’s prestigious hospitals.

Conventional thinking was that health insurers, many of them now national public companies whose stock traded on the New York Stock Exchange, would contract for their customers’ health benefits with hospital systems that could offer a full menu of services across the wide swaths of geography that its members inhabited. The Cleveland Clinic and University Hospitals set out to build their comprehensive health systems, filling in gaps so that each had all the components a patient would need from cradle to grave, as the span of services often was described. The flurry of activity re-ignited the historical tension between UH and the Clinic.

To match the neonatal intensive care unit at University Hospitals’ Rainbow Babies’ and Children’s Hospital, the Clinic built its own; to compete with UH’s Ireland Cancer Center, the Clinic built Taussig Cancer Institute. UH set out to capture a third of the market, “to feed” the specialists housed in its flagship tower in University Circle, and added its own health plan. To build its capacity in cardiac care—whose care was long dominated by the Clinic—it hired an entire group of cardiologists from Mt. Sinai Medical Center, an increasingly frequent casualty in the medical arms race waged by the Clinic and UH.

The one-upmanship spilled into primary care, a battle that was fought in the suburbs. With primary care doctors as gatekeepers to specialists, the big hospitals would have to get more of them in more places to refer to its towering flagships. Multi-storied medical buildings popped up along highways on suburban commuter routes with the Clinic logo; UH added new outpatient centers, too, and hired more primary care doctors.

Within each of the storied institutions came reminders of the relative advantages of each model. UH’s doctors practiced medicine as private doctors and were professors, with the independence afforded by academic freedom; Clinic doctors were Clinic employees, making its organization more nimble in changing times. The historical competition was played out in hospitals and medical offices across the region as UH and Clinic leaders fought to win the hearts and minds of physicians, hospital administrators, and paying patients. Farah Walters, UH’s chief executive officer, seemed to be channeling the prickly Dudley Allen of 1899, while Floyd D. Loop, the Clinic’s chief, personified the cool George Crile. To those they courted, it often seemed to be about choosing sides.

The battle for market share heated up dramatically when the largest for-profit hospital system in the country stuck its flag in Cleveland soil and declared that it soon would command a third of the health care market. Community hospitals across the region started looking for a friendly merger to ensure their futures. The Cleveland Clinic and University Hospitals fought vigorously to win the most prized among them, battles that often landed in newspapers and the courts.

When the dust settled, the health care landscape was forever altered. The rapid consolidation in the 1990s left Cuyahoga County with three health care systems (not counting the federal Louis B. Stokes Veterans Administration Hospital), when the beloved

and beleaguered Mt. Sinai Medical Center closed in 2000. Remaining are two large organizations that account for the lion's share of the county's health care, the Cleveland Clinic Health System, which has more than \$5 billion in annual revenues and University Hospitals Health System, which has nearly \$2 billion in annual revenues. The MetroHealth System, the county-owned safety-net health system has just one hospital and a \$760 million budget. In Cuyahoga County, only two other general hospitals, Parma Community General Hospital and St. Vincent Medical Center, are not owned or in some way linked with the Clinic or UH.

The Cleveland Clinic, University Hospitals, and the MetroHealth System continue to bring distinction to Greater Cleveland. For all the changes that ensued in the tumultuous 1990s, Cleveland is fortunate to have some of the top-ranked health care organizations in the country. Health care is the region's largest employer. The sector continues to grow, one of the few to do so, as the economy continues its transition from its historic manufacturing base.

The Clinic and UH continue to add new buildings and enhancements to their existing campuses and patient care.

The Clinic, which has drawn kings and princes from around the world to Cleveland, has become truly international, with a new medical center opening in 2012 in Abu Dhabi, United Arab Emirates; and a facility in Toronto. It employs 2,000 physicians and scientists, who represent 120 specialties and subspecialties, and recorded more than 4.2 million visits from patients across the region, the United States, and from 80 other nations. In *U.S. News and World Report* rankings, its heart program has topped the national list for 16 years.

University Hospitals Case Medical Center has two new hospitals in the final phase of construction that will bring the latest thinking about hospital care to the Ahuja Medical Center when it opens early in 2011 in Beachwood, and to cancer patients at its new Ireland Cancer Center on the main hospital campus. Its pediatric neonatology program at Rainbow Babies' and Children's Hospital was ranked fourth in the country in *U.S. News's* last report. Case Western Reserve University's School of Medicine and University Hospitals, CWRU's primary teaching partner, together form the largest biomedical research center in Ohio.

MetroHealth Medical Center continues its historic commitments to serve those who are most in need, as well as to research and education. Its Emergency Room is the region's busiest, posting more than 92,000 visits in 2009, and its rehabilitation program ranks among the top centers in the country and includes one of 14 model centers for treating spinal-cord injuries. MetroHealth's nine community health centers provide access in neighborhoods where residents live and shop, and a new health center catering to the elderly replaced a shuttered hospital on which the aging neighborhood had relied. It was the nation's first safety-net hospital to fully implement an electronic medical record system, a vital tool for delivering high-quality care.

To be sure, Cleveland is a great place to be, if you become seriously ill or are injured in an accident. But it's become clear that medical technology and scientific knowledge alone are insufficient to address our modern-day epidemics of lifestyle-related conditions, such

as obesity and diabetes. Chronic diseases, such as diabetes, account for 75% of the nation's \$2.3 trillion annual health care bill.

The ever-rising cost of health care and the high prevalence of chronic disease demand some new ways to think about what constitutes high quality health care. No matter how “good” a doctor is, the best outcomes come when the right care is delivered at the time that is right for the patient. That means that care is based on the best available medical evidence, that it is coordinated among a patient's doctors, and that it includes and respects the patient in decisions about treatments.

Consumers have to play a part in this intellectual shift, too, by asking questions, being informed about healthy behaviors and demanding high-quality care. And we have to understand that quality of care is not the same as the quantity of care. Often, more care is not better care, it is just more—or worse—it is harmful. And it costs everyone too much, without making us healthier.

A typical family spent about \$15,000 in 2009 for health care¹⁵—more than you'd pay for a spanking new Nissan Cube. Health care has become a huge part of the U.S. economy, accounting for 17.3 percent (!) of spending. The federal government, which foots the bill for nearly half of the nation's health care tab through its Medicare and Medicaid programs, since the 1970s has tried different strategies to rein in costs. It's been a tough road, because new medical technology is expensive and because we pay doctors and hospitals to treat sick people, with little or no payments to help their patients stay healthy and out of the hospital.

For example, if you have health insurance and go to the doctor for a sore throat, your doctor may test for strep infection and write a prescription. The doctor can bill your insurance company for your visit. But if someone is diagnosed with diabetes, the doctor can't be reimbursed for a visit to teach them how to change their diet, test their blood sugar, and do other things to manage this serious, ongoing condition—one that without good self-management can cause blindness, amputations, heart disease, and kidney failure. In the end, these complications cost everyone more, especially in the quality of life for patients and their families.

The good news is that, while Greater Cleveland's large medical centers still compete, they also are collaborating to help make our region healthier. Greater Cleveland has become a recognized leader in the national movement to improve the quality and value of health care by “competing” on quality, by measuring and publicly reporting their achievement on meeting nationally accepted standards of good care and optimal outcomes. By measuring their performance, they identify gaps in the care they provide and the outcomes that their patients receive, then find ways to improve them.

New federal incentives promise to help, too, by encouraging health care providers to switch from paper medical charts to electronic medical records. Electronic records can be programmed to remind doctors to order a test, to provide information on evidence-based treatments, and to show progress toward improving their patients' care. Did they remember to check for up-to-date vaccinations?

Today, the federal government reports the performance of nearly all hospitals on selected standards of quality care at HospitalCompare.hhs.gov. In Greater Cleveland, more than 400 primary care doctors in 45 practices from different health care systems publicly report their achievement on standards for effective care of people with common chronic

conditions through a collaboration known as Better Health Greater Cleveland. These rankings soon may get more ink than the “best hospitals” lists in glossy magazines, which speak more to popularity than actual patient outcomes. That will require a mental shift for consumers, one the Flexner Report noted in 1910.

Also gaining steam in Greater Cleveland is a new model of care that once again looks to generalist doctors and the supporting casts in their medical offices to play a bigger role in our health care—and to give patients the access, information, and help they need to coordinate their care in this complicated health care system. Why shouldn’t we get post-cards to remind us that we are due for a check-up? Our pets’ veterinarians send them. Why can’t we use e-mail or phone calls to follow up with doctors or nurses? It sounds like simple stuff, but it hasn’t happened, because the payment system won’t pay the offices for it. And the generalist doctors, the ones who best know us, our families, and our medical history, already are paid far less than specialists.

But the other way that health care will get smarter and our region will become healthier is if consumers stop thinking of their health insurance card like it’s a Visa card that never has to be paid. Even with rising costs to the consumer through co-payments for doctor’s visits and other out-of-pocket expenditures, those of us with insurance are still insulated from what medical care really costs. Just because we pay only \$35 for the \$1,200 MRI the doctor orders for the sore back we got after doing yard work all weekend doesn’t mean we shouldn’t ask why such a costly test is necessary.

As consumers, we should be asking our doctors more questions, not just because of the cost, but because the risk of harm from some treatments may exceed the expected benefit.

Shouldn’t we know at least as much about our health as we do about our smart phones?

ENDNOTES

1 Michael Haines, "Fertility and Mortality in the United States," in *EH.Net Encyclopedia*, ed. Robert Whaples (March 19, 2008).

2 Robert L. North, "Benjamin Rush, MD: assassin or beloved healer?" *Baylor University Medical Center Proceedings* 13, no. 1 (January 2000): 45–49.

3 Mark Gottlieb. *The Lives of University Hospitals of Cleveland: The 125-Year Evolution of an Academic Medical Center* (Chesterland, OH: Octavia Press, 1991)

4 Ibid.

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