On July 19, 1977, I hesitantly walked into a small office located in a distinctive “building on stilts” across from Fairview Southdale Hospital in Edina. The office had four exam rooms, a narrow waiting room with a long couch and a few chairs, and six employees, including one bookkeeper who doubled as an overseer and one billing person who processed charges by hand. The doctors wrote all notes in degrees of legibility that varied from the mostly readable to the hieroglyphic. The practice operated two offices, and the five internists I was joining went to three hospitals almost daily. As I eased into the practice, I spent my mornings driving an unconscionable number of miles to get to all the hospitals, seeing patients and schmoozing with other physicians to get “known.”

Back then, hospitals were the hub of medical practice, housing patients for what now seem like interminable stays. Cataract patients stayed five days as did hernia patients. Myocardial infarctions stayed at least two weeks. Doctors were still admitting patients for “GI workups” that included a barium swallow and a barium enema. All this activity demanded a lot of hospitals, among them Metropolitan Medical Center, Deaconess, Mt. Sinai and Eitel—now tombstones in the graveyard of Minnesota medical history.

That hospital-based style of practice was possible not only because it was deemed acceptable but also because patients and insurance companies would pay for it. For most medical groups, any money that didn’t flow directly from patients came from Medicare or insurance companies that paid “usual and customary” fees. Those halcyon days evaporated as insurance companies became HMOs and Medicare adopted DRGs. Suddenly, hospitals were financial black holes that patients needed to avoid. The length of stays plummeted, and physicians found ways to treat patients without admitting them.

Over the years, my group expanded and contracted. We moved offices, we enlarged offices, we shared offices, we closed offices. As hospitals shuttered and hospital practice slackened, we abandoned our freeway life and settled into a one-office, one-hospital practice. We stoically adapted to the managed care revolution and to corporate consolidation. What we didn’t accommodate was the seismic change in hospital practice.

My group’s demise really happened because of hospitals. At least one of my partners and most potential new partners emerging from residency no longer wanted to practice in both the office and the hospital. After my group shrank to a financially unsupportable size, we folded and I became an office-only doc. My peripatetic, hospital-hopping days now seem like a distant dream.

Some of the historic tales in this issue that highlights past and future seem like fantasies born of dream states—hospitals for “imbeciles,” cleaning ladies stanching life-threatening hemorrhages. Equally fantastical are the predictions for hospitals that will feature outpatient coronary bypasses or clever robots saving lives.

We view the past and we can’t believe it was ever like that. We look into the future and we can’t believe it will ever be like that.