Medical Group Practice

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THE concepts and actualities of medical *group* practice have been a matter of much discussion in recent years. Of late, there has been growing acceptance of it as a form of medical practice, but its best forms and proper place in health care are still uncertain.[1] Factual information has been lacking for the answers to certain of the key questions involved. The most extensive study of the subject was initiated by the United States Public Health Service early in 1946. This study, which is still engaged in analysis of a wealth of data assembled for the purpose, has already provided extensive published results.[2] Its findings form the basis for many of the observations in the present article.

Teamwork in Modern Medicine

The growth and complexity of modern medical knowledge have made it essential to organize the general practitioner, specialist, laboratory, X-ray, and other essential medical personnel into a cooperating team. With a group practicing together in a well-equipped medical centre, increased efficiency and improved quality of medical care can result. To the extent that preventive, hospital, dental, drug, optical, social and other services are added to the basic clinic office and home doctor care, groups may lay claim to making available comprehensive modern medical service.

In the United States, the Mayo Clinic was the first well-known medical group in the modern sense, although the old charity dispensaries and hospital outpatient departments (especially those in medical schools with the "full-time" system, such as Johns Hopkins) were even prior examples. The Mayo family established their clinic in 1887, following experiences in providing disaster relief in 1883 in Rochester, Minnesota. The clinic was first organized as a private group and later re-organized as a nonprofit foundation with medical school sponsorship.

Since that time, there has been a steady growth of medical group practice in the United States as well as in other parts of the world. The development has been very rapid in the Soviet Union in the last twenty-five years, while Britain now plans to base its National Health Service on group practice in health centres. It should be noted that in Britain the term "group practice" is used more for grouping of general practitioners than in the United States, where it usually refers to associations of specialists with or without general practitioners.

What Is Group Practice?

There are certain very different forms of medical organization which are called group practice, and definitions of the concept found in the literature vary widely. First, it is necessary to point out a frequent error by differentiating between group prepayment, a way of *paying* for medical service, and group practice, a way of *providing* it. Although the two are sometimes associated, they often do not go together in the United States.

The Bureau of Medical Economics of the American Medical Association uses the specifications formulated by Leland: a group must include at least three physician members, and the receipts from medical practice must be pooled and redistributed to the members according to some previously arranged

1. A summary of some of the main questions is given by G. Halsey Hunt in "Medical Group Practice in the United States," *New England Journal of Medicine*, 237:71:1947. See also a penetrating British evaluation of the subject in "Medical Group Practice in the United States," in *Planning*, vol. 14, no. 274, 14 Nov., 1947, issued by P.E.P. (Political and Economic Planning). The Bureau of Medical Economic Research of the American Medical Association has recently released an extensive guide, *Annotated Bibliography of Group Practice*, 1927-1947.

2. G. H. Hunt and M. Goldstein, "Medical Group Practice in the United States: II, Survey of Five Groups in New England and the Middle Atlantic States," *N.E.J.M.*, 237:719:1947; "III, Report of a Questionnaire Survey of All Listed Groups," *Journal of the American Medical Association*, 135: 904:1947. M. Goldstein, "IV, Organization and Administrative Practices," *J.A.M.A.*, 136:857:1948. I am deeply indebted to these authors for information and advice on the subject of group practice.

plan. "Closed staff" hospitals are not included, unless the staff members pool income for services outside the hospital. Purely "diagnostic" groups receiving only referred cases and "industrial" groups furnishing medical services to a single industry are also excluded from the Bureau's studies.

The Committee for the Study of Group Medical Practice defines it as "the application of medical service by a number of physicians working in systematic association, with joint use of equipment and financial organization."[3] For the Public Health Service study, Hunt has defined group practice as a formal association of at least three physician members, practicing together full-time, using common facilities, and providing more than a single medical speciality.

The custom of sharing office suites and secretarial, nursing and perhaps other personnel now common among physicians, especially in Medical Arts buildings, but not sharing income and patients, is insufficient to qualify such an arrangement as group practice under these definitions. Also excluded are clinics operating under the auspices of certain teaching hospitals, industries, labour unions and public agencies, when these are staffed only on a part-time basis—although they clearly represent a type of organization worthy of considerable study. The staffs of most voluntary hospitals, especially of teaching hospitals, engage in group practice of medicine within certain limits, but these organizations are not regarded as coming within the terms of reference as usually understood. Groups of physicians practicing a single specialty are not considered full medical groups. In the study, they were all classified as reference organizations, except in the case of a grouping of specialists in internal medicine.

In 1946, there were 349 service and 19 reference groups in the United States reported to the Public Health Service study and considered as meeting its definition of group practice.[4] The service groups provide day-to-day, continuing medical service in the clinic, home or hospital, performing functions analogous to those of the general practitioner plus consulting specialists. Well-known organizations of this type include the Duluth, Scott-White and Endicott-Johnson Clinics, Group Health Association of Washington, D. C., the Mary Imogene Bassett and the Kaiser-Permanente Hospitals. Reference groups, on the other hand, provide diagnostic, consultant or specialized treatment services for referred patients who are then returned to the referring physician, ordinarily in a relatively short time, or are retained for specialized therapy. The Mayo, Lahey, and Cleveland Clinics are notable examples of this category. Some reference groups provide diagnostic services only. Most groups show a mixture of both types of relationship, and can be classified only by the major emphasis in their practice.

Type of Organization

A group may be primarily organized by its constituent physicians or it may be sponsored by a hospital, medical school, industry, consumer groups (such as a consumer co-operative or a labour union) or a government agency.

The first-named is by far the most common in the United States, representing about nine-tenths of the 368 groups which were reported to the study in 1946 and regarded as meeting the Public Health Service definition. Most of these were partnership groups with employed physician members. Ownership of the physical assets (building, equipment and supplies) may be quite different from the organization for the practice of medicine, with participation in the former often being restricted to the senior partners. Frequently the same physicians have a corporation for ownership

3. *Group Medical Practice: Tentative Statement of Principles and Procedures.* Committee for the Study of Group Medical Practice, March, 1940.

4. See Table I for analysis of the reported groups.

Table I

SELECTED DATA ON 368 MEDICAL GROUPS IN THE UNITED STATES, 1946[1]

Number and Percentage of Groups with Specified Characteristics

Category	Item	Number	Percentage
TOTALS	All Groups	368	100.0
Type of Group	Service	349	94.8
	Reference	19	5.2
Location of Groups by Major Region[2]	Midwest	162	44.0
	South	97	26.4
	West	84	22.8
	Northeast	25	6.8
Population (in thousands) of Communities in which Groups are located	Under 5	59	16.0
	5- 10	66	17.8
	10- 25	89	24.3
	25-100	89	24.3
	100-500	50	13.6
	500 and over	15	4.0
Number of Full-Time Physicians in Group	3- 5	194	52.7
	6-10	101	27.4
	11-20	58	15.8
	21 and over	15	4.1
Ownership of Group	Physicians	342	92.9
	Hospitals	10	2.7
	Consumers	8	2.2
	Industrial	7	1.9
	Government	1	0.3
Groups having "own" Hospital	Total: All Groups owning or controlling a Hospital	117	31.8

1. Adapted from G. H. Hunt and M. Goldstein, "Medical Group Practice in the United States: III—Report of a Questionnaire Survey of All Listed Groups," *Journal of the American Medical Association*, Vol. 135, pp. 904-9, 1947.

2. The states in each region, with the numbers shown in parentheses, are as follows:
Midwest—Ohio, Michigan, Indiana, Illinois, Wisconsin, Minnesota, Iowa, Missouri, Kansas, Nebraska, South Dakota, North Dakota (12);

South—North Carolina, South Carolina, Georgia, Florida, Kentucky, Tennessee, Alabama, Mississippi, Arkansas, Louisiana, Oklahoma, Texas, Maryland, Delaware, Virginia, West Virginia, District of Columbia (16 and D. C.);

West—Montana, Washington, Oregon, Idaho, Wyoming, Colorado, Utah, Nevada, California, Arizona, New Mexico (11);

Northeast—Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, Pennsylvania, New Jersey (9).

of the physical assets but constitute a partnership for the practice of medicine, dividing net income among themselves, and perhaps with employed salaried physicians, in a predetermined manner. Sharing of the pooled net income is often on the basis of the partners' capital investment plus various devices for measuring their professional and financial value to the group. Employed physicians are ordinarily on fixed salary, but may receive additional income from the group in the form of bonuses and the like. Groups sponsored by non-medical agencies consist primarily of salaried physicians, with the rate of remuneration being based usually on length of service and/or experience, specialist qualifications (such as American Specialty Board certification), responsibility, and ability. In some cases, the salary is supplemented by bonuses and retention of fees for home calls and other services.

Most groups have a medical director as the top administrative authority, but in large partnership groups an executive committee, composed usually of the most senior partners, often performs this function. A lay business manager is ordinarily employed in all but the smallest associations. In consumer - sponsored groups the lay executive directors tend to have more responsibility and authority than do the business managers of other kinds of groups.

Location of Groups

Four States — Minnesota, California, Texas and Wisconsin — contained over a third of all the reported groups in the United States, with 1,190 of the 3,084 physicians in full-time group practice in 1946. In general, the New England, Middle Atlantic and Southeastern States reported very few groups, while the North Central, Southwest and Pacific States showed the most.

Only about a third of the groups were located in communities with less than 10,000 population, where 53.3 per cent of the nation's population lived in 1940. These tended to be the smaller groups, but some in rural areas were surprisingly large and specialized. About half the groups in 1946 were located in cities of over 100,000 population, although these centres contained only 29.7 per cent of the population in 1940. There were very few groups in the largest cities in the United States in 1946: communities with 500,000 population and over, which accounted for 17 per cent of the 1940 total, claimed only four per cent of all groups at the time of the survey. This distribution has probably changed in the last three years—the groups now developing in New York City under the stimulus of the Health Insurance Plan of Greater New York, for example, would be enough to change the relative distribution figures strikingly.

Staff and Services

Small groups are considerably more common than large ones, over half the groups having three, four or five full-time physicians. Some organizations, however, have very large staffs indeed: the Ross-Loos Clinic had 95 and the Mayo Clinic 250 full-time physicians in 1946. The median number of physicians per group in that year was five on a full-time basis. In addition, there was an average of one part-time physician per group, particularly with the larger associations.

Home, office and hospital care is usually provided, although the proportion of home calls is small compared with that under solo practice. Surgery and internal medicine are offered by almost all groups as the primary specialty services. These are supplemented by obstetrics, gynecology, and X-ray in over 80 per cent of the reported general medical care groups, while pediatric, ear, nose and throat, and eye service was provided by well over half. Dentistry was offered by about a quarter of all the groups studied.

For the reference groups, distribution

of the specialities covered was roughly similar to that for the service groups. One major exception should be noted: obstetric, gynecological and pediatric services were provided by considerably fewer reference groups than was the case for the service organizations. The average service group offered almost 7 specialties, while the reference groups provided 5.6 on the average. The 56 prepayment groups known in 1946 offered an average of 7.3 specialities.

The kinds of medical problems presented to groups and the medical procedures of these organizations are now under study by the Public Health Service project. The medical records of suitable samples of patients are being used as an important source of such information. The records appear to indicate rather striking differences between one clinic and another in the types of illness presented by patients, in the nature of the diagnostic "work-ups," and in the preventive and therapeutic services offered. It is considered that this approach may provide some key indices for studying the quality of medical care in both group and individual practice.

About a third of the known groups own their own hospitals, or represent such a large proportion of the hospital staff that the institution is under group control. The others rely primarily on staff privileges in voluntary hospitals.

Prepayment Groups

Some 15.2 per cent of the groups listed by the United States Public Health Service in 1946 had what might be called "their own" prepayment plans.[5] An additional 50 per cent participated in prepayment plans under other auspices, including Blue Cross, Blue Shield, cooperative, commercial or other types. A considerable proportion of this category is comprised of industrial groups of various types — voluntary prepayment plans having along history among industrial workers in the United States as well as abroad—and of private physicians' groups. Consumer-sponsored prepayment organizations represent a small proportion of the total, but appear to be of growing importance.

Most of these groups provide rather comprehensive medical care, including office, home and hospital service for the insured and their dependents, although some industrial groups provide service only to the workers themselves.

Canadian Groups

Information concerning only nine Canadian groups is available in the files of the Public Health Service study on group practice, although many more undoubtedly exist. Of these nine, questionnaire returns giving basic data were received from four. These groups are all relatively large, ranging from 10 to 23 full-time physicians. One has, in addition, a full-time dentist. They have between 5 and 20 full-time nurses.

Two are partnership groups with employed physicians. A third is a corporation of members with employed doctors. The fourth is a partnership for clinical work and a joint stock company of the partners for ownership of the physical assets.

Two of the four Canadian groups have medical directors. One is governed by a medical board, with the chiefs of the medical and surgical departments sharing the function of medical director. One has no medical director or equivalent officer. Three have business managers, while in one this function is carried by the medical director.

Three of the four are service groups, while the fourth is a reference group. None maintains its own prepayment plan but one cares for patients of a medical service plan. None of them has a hospital of its own.

The medical services provided vary. All the clinics cover medical, surgical, gynecological, and X-ray service. Three

5. See Table II for analysis of medical group prepayment plans.

of the four offer obstetrics and urology. Two specify service in pediatrics, psychiatry and otolaryngology. One clinic covers, in addition, orthopedics, allergy and dermatology. Ophthalmology is included by one clinic and dentistry by another.

Attitudes Toward Group Practice

The majority of physicians in the United States probably look with favour on group practice, especially when the groups are organized on a private (physician-owned) basis. This is indicated rather clearly by results of a war-time poll of physicians in the Armed Services taken under the joint auspices of the American Medical Association and the Armed Forces Medical Corps.[6] The poll showed that well over half of these physicians wished to enter group practice after their release from the Armed Forces.

This finding tends to be confirmed by other smaller polls such as that taken under the auspices of the Rhode Island Medical Society, as well as by recent statements concerning group practice in the medical press. Gregg[7] stresses the influence of modern medical education—especially in schools with the "full-time" system—in fostering the young physician's preparedness for group practice. Approval of group practice by representatives of organized medicine in the medical care panel statement adopted recently at the National Health Assembly is likewise significant for the future. There seems little doubt that public favour is also growing, although the economic issue of meeting medical bills undoubtedly bulks larger in the consciousness of the average person.

Obstacles to Group Practice

How, then, can one explain that less than three per cent of all active practitioners in the United States are practicing full or part-time in group practice?

The answer to this question is certainly one of the most important to seek if we are to provide better medical care for more people. No studies have yet supplied the full basis for an answer, but certain facts seem clear, and speculation may perhaps be forgiven for the rest.

As far as the formation of physician-owned groups is concerned, one must recall the general lack of information regarding the principles and experience of group practice, as well as the relatively recent change in professional attitudes. In the midst of a competitive economy and a medical world whose dominant current ethics and ideas are those of individual practice, as is the case in the United States, the concepts of group practice have not come easily. Medical education has introduced medical students and resident physicians to the experience of group practice in teaching hospitals, but, at the same time, its teaching has emphasized preparation for individual practice instead.

Finances. The initial capital investment for a clinic building and equipment is very sizeable indeed, running into the tens of thousands and hundreds of thousands of dollars, exclusive of the cost of hospital facilities. Overhead is large, and the problem of maintenance funds is a serious one. Continuing funds must come ordinarily from fees or from voluntary prepayment plans, supplemented perhaps from public or industrial sources. Fees are notoriously uncertain, especially during economic depressions, while voluntary prepayment plans have, and will continue to have, many attendant difficulties. Agreement on division of income to please the participants is also not easy, but the successful achievement of an equitable distribution is a prerequisite for a private group's foundation and survival. Certain methods have been devised and are being used successfully, but some students of the subject feel that the not inconsiderable

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6. Harold C. Lueth, "Economic Aspects of Future Medical Practice," *Journal of the American Medical Association*, 128:528-529:1945.
7. Alan Gregg, "Group Practice and Medical Education," in *Benefits of Group Practice: The Kingsley Roberts Memorial Lectures*, 1948. Medical Administration Service, Inc., 1790 Broadway, New York, N. Y., May, 1949.

mortality of groups is more often due to the problem of income division than any other single difficulty.

Administration. Good administration of a group is difficult to achieve. High quality leadership is essential and is not always forthcoming. There is little in the average physician's training which would give him administrative experience or ability, yet the relationships of the various partners and employed physicians, auxiliary personnel and patients, are difficult to adjust and must be handled in a mature manner.

Establishment. Opportunities for apprenticeship experience in existing groups are not numerous, for positions are offered primarily to established specialists who are already qualified. Many interested physicians are thus faced with the necessity of forming their own groups, with the attendant obstacles noted above. But adequate published information on the successful ways of building group practice, in terms of medical, fiscal, legal and administrative procedures and problems, has been lacking. As a result, these difficulties may loom very large indeed, especially if qualified expert consultants are not available or are not known.

Consumer-sponsored groups face the delicate problems of recruiting medical personnel into organizations whose major administrative policies are not controlled by the participating physicians and dentists, even if the professional policies are, and in achieving a stable membership base with adequate purchasing power to support the group. Much the same can

Table II

MEDICAL GROUP PREPAYMENT PLANS IN THE UNITED STATES, 1946[1]

Distribution By Sponsorship

Sponsorship of Plan	Groups with "Own" Number	Prepayment Plans Percentage	Percentage of Total Listed Groups in 1946
TOTALS	56	100.0	15.2
Physicians[2]	29	51.8	7.8
Industrial[3]			
Company	7	12.5	1.9
Physician organization[4]	7	12.5	1.9
Employees mutual or labour union	5	8.9	1.4
Subtotal	19	33.9	5.2
Consumer Co-operative	4	7.1	1.1
Hospital or Medical School	3	5.4	0.8
Government	1	1.8	0.3

1. Data in this Table concern Medical Groups with their own prepayment plans. Some of these and other groups also participate in prepayment plans sponsored by other organizations—for example, Blue Cross Blue Shield, commercial or consumer plans.

2. These physicians' groups differ from others in having no single major sponsoring organization or affiliation, if any at all. They may, however, have contracts with industry, consumer groups, public agencies, or oth er rganizations.

3. Industrial groups, as defined here, are those whose patients are altogether, or for the most part, the employees of a single company or industry, with or without their dependents. These may be organized by an industrial company, a group of physicians, an employees' mutual benefit association or a labour union, as indicated in the sub-groupings of this section.

4. Three of these physicians' groups, all related to each other, were incorpo rated as non-profit foundations

be said for industry-sponsored groups. It must be admitted that some organizations in these two categories have not understood the professional and financial needs of their physicians and auxiliary personnel adequately. This situation, which undoubtedly has been due mostly to lack of experience, has inhibited the growth of such organizations. Perhaps more serious is the great hesitancy of medical bodies to approve groups not sponsored by physicians. In the United States, this has resulted, in 21 States, in legislation which can accurately be called restrictive, since medical care plans are thereby limited, in effect, to those sponsored by physicians, and even then to plans of the type approved by a majority of the physicians in an area.

Future of Group Practice

Group medical practice will undoubtedly grow in the United States. Acceleration of the trend is possible through fuller knowledge of the principles and experiences of medical groups, their proper place in health care, the availability and use of qualified expert consultants, the provision of subsidy funds for capital expenditures for those types of groups considered to be in the public interest, and correction of the legal barriers to group practice. Concomitantly, spread in the use of prepayment and tax funds will assist in the provision of maintenance funds. The linking of groups with the medical school, the hospital, the health department, professional societies and community organizations of various types will aid in the provision of sounder programs and will serve as standard-setting and standard-raising devices.

It seems likely that group practice will make substantial contributions to the medical care made available in the period that lies just ahead.