RECOMMENDATIONS OF THE PRINCIPAL MINORITY GROUP

I

The minority recommends that government competition in the practice of medicine be discontinued and that its activities be restricted (a) to the care of the indigent and of those patients with diseases which can be cared for only in governmental institutions; (b) to the promotion of public health; (c) to the support of the medical departments of the Army and Navy, Coast and Geodetic Survey, and other government services which cannot because of their nature or location be served by the general medical profession; and (d) to the care of veterans suffering from *bona fide* service-connected disabilities and diseases, except in the case of tuberculosis and nervous and mental diseases.

II

The minority recommends that government care of the indigent be expanded with the ultimate object of relieving the medical profession of this burden.

III

The minority joins with the Committee in recommending that the study, evaluation, and coordination of medical service be considered important functions for every state and local community, that agencies be formed to exercise these functions, and that the coordination of rural with urban services receive special attention.

IV

The minority recommends that united attempts be made to restore the general practitioner to the central place in medical practice.

V

The minority recommends that the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed as being economically wasteful, inimical to a continued and sustained high quality of medical care, or unfair exploitation of the medical profession.

VI

The minority recommends that methods be given careful trial which can rightly be fitted into our present institutions and agencies without interfering with the fundamentals of medical practice.

VII

The minority recommends the development by state or county medical societies of plans for medical care.

MINORITY REPORT NUMBER ONE

BY

A. C. CHRISTIE, M.D., GEORGE E. FOLLANSBEE, M.D.,
M. L. HARRIS, M.D., KIRBY S. HOWLETT, M.D.,
A. C. MORGAN, M.D., N. B. VAN ETTEN, M.D.,
A. M. SCHWITALLA, PH.D., OLIN WEST, M.D.,
AND ROBERT WILSON, M.D.

* These sections bear the same numbers as the corresponding sections of the Majority Report.

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The minority group of the Committee whose names are subscribed to this report are in accord with the majority in many of their conclusions and recommendations. We find ourselves, however, in conflict with what we conceive to be the general tone or trend of the report and in certain instances in sharp disagreement with the recommendations for future action. We have also certain constructive suggestions to make which have been omitted or the importance of which has not been sufficiently emphasized in the report of the majority. We regret the necessity for a minority report, but we are convinced that we would fail in our duty both to the public and to the medical profession if we did not point out as forcibly as possible what we conceive to be unwise recommendations or omissions in the majority report of this Committee.

We are in full and hearty accord with the majority in its recommendations for "The Strengthening of Public Health Services" and "Basic Educational Improvements," and we agree to some extent with the pronouncements of the Committee in respect to coordination of medical services. The first effect of "strengthening public health services" will be a considerable increase in the total cost of medical care, but we have the hope that eventually great savings will come from decrease in the incidence and duration of certain diseases.

Some of the recommendations for coordination of medical services and for basic improvements in medical education are immediately practicable and will undoubtedly result in reductions in the costs of medical care. They are in line with the general progress of medicine and are based on sound experience. Many educational improvements are under way through the initiative of the medical and dental professions and college authorities. Among them one of the most important is the increasing emphasis upon the necessity for more thorough training of the general practitioner in all of those fields which only he can adequately fill. In this connection we call attention

to the fact that neither scientific medicine nor the organized professions have been unprogressive. They have assumed initiative and have maintained leadership in the advancement of scientific knowledge and in improving the methods of its application to human welfare. In the opinion of the minority the general trend of the majority report makes it appear that the medical profession has been static and unprogressive. This implication we believe to be unjustified by the history of medical progress.

We are in sympathy with the recommendations of the majority which deal with the better training of specialists and their proper control. This is another matter in which the medical profession has taken the initiative. There are already several specialties which have organizations for the certification of specialists. Extensive plans are being perfected by some state medical societies and by the American Medical Association looking to establishment of control of specialism. It should be remembered that specialism has made great contributions to medical progress. Its abuses are capable of control by the professions without any revolutionary changes.

We repeat that this minority is heartily in accord with the majority recommendations with respect to public health and progress in medical education.

With regard to the majority Recommendations 1 and 3, dealing with " Organization of Medical Services " and " Group Payment for Medical Service," the convictions of this minority are so divergent from those of the majority that they must be discussed in detail.

I. ORGANIZATION OF MEDICAL SERVICES

The minority group recognizes the desirability of better correlation of the activities of the professions and it is in agreement with the majority upon some of the suggestions under the above heading. There is nothing, however, in the facts elicited by the Committee nor in the general experience of the medical professions to lead us to believe that " organization " can accomplish what is claimed for it in the majority report. On the contrary, it seems clear to us that many of the methods advocated will give rise to new and greater evils

in the attempt to cure existing ones. Our views are set forth below under each heading of the majority report.*

1A. Community Medical Centers.—The emphasis placed upon this plan which is called "the Committee's most fundamental specific proposal" we believe to be far beyond any possibility of its ultimate value. It is admittedly an idealistic plan based almost solely upon theory. There is nothing in experience to show that it is a workable scheme or that it would not contain evils of its own which would be worse than those it is supposed to alleviate. Above all there is no evidence to prove that it would accomplish what ought to be the first object of this Committee, the lessening of the costs of medical care. The plan is suggestive of the great mergers in industry, the main medical center being in the nature of the parent holding company governing the activities of subsidiaries and branches. The idea that size and power are synonymous with excellence and efficiency has received some severe blows during the current economic depression, and opinions concerning it are undergoing revision.

The medical center plan is the adoption by medicine of the technique of big business, that is, mass production. It seems almost impossible for those who are not engaged in the practice of medicine to understand that the profession of medicine is a personal service and cannot adopt mass production methods without changing its character. It is always the individual patient who requires medical care, not diseases or economic classes or groups. The neglect of this principle in other fields

* *Additional Statement by Member of Minority Group.*—My major objection to the recommendations of the Majority is against group practice and not against group payment. I favor group payment in the compulsory, as opposed to the voluntary, form. But I oppose group practice. From Publication 27, we learn that 40,000,000 people of the United States live in rural areas and in towns of less than 2,500 population, where there are no hospitals around which to form group clinics and where there are not enough physicians, dentists, and other professional personnel out of which to form group clinics that could furnish complete medical care. Therefore I would recommend that in all such communities every family be urged to select a family physician to whom shall be submitted all health problems as well as illness problems; that we urge the cooperation of this family physician with available laboratories, specialists, etc., the free use of all such whenever needed and the close coordination of such service in rendering adequate and complete medical care. This would preserve the essential personal relationship between physician and patient and restore the private general practitioner to his rightful place as the *key-man* in any effective system of rendering medical service. I consider this kind of cooperation better and fairer to all parties than the organization of such personnel into partnership groups.—Kirby S. Howlett.

has brought serious evils that are now being corrected only with great difficulty. When mass operation revolutionized industry, social movements tended to follow the industrial pattern. Even education took on many of the factory forms. Educators, social workers, and penologists are now all emphasizing the value of individual case work. Yet in none of these fields are the problems so intensely personal and individual as in that of medical diagnosis and treatment. Nowhere is there greater need of complete liberty of action and close continuous knowledge of the person to be treated nor greater necessity for confidence than in the relation between patient and physician. Medicine has accepted the modern idea of cooperation but has rejected the competitive, mass-production idea of the factory system as being destructive of the social values developed by professional traditions.

Among the many objections to the medical center plan which must occur to anyone familiar with the requirements of medical practice are the following: (1) It would establish a medical hierarchy in every community to dictate who might practice medicine there. This is inherent in the plan since any new member of the center must be chosen either by the chief or by a small staff. (2) It would be impossible to prevent competition among the many such centers necessary for large cities; cost would inevitably be increased by the organization necessary to assign patients to the various centers. This would add to the evils of medical dictatorship those of a new bureau in the local government with its attendant cost. (3) Continuous personal relationship of physician and patient would be difficult if not impossible under such conditions.

We look upon this plan as far-fetched and visionary. It has no practical relationship to the question the Committee has set itself to solve. Placed as it is at the very beginning of the Committee's recommendations it must create a doubt of the Committee's grasp of the problem to which it has addressed itself. It seems to us an illustration of what is almost an obsession with many people, namely that "organization" can cure most, if not all, human ills.

1B. Industrial Medical Service.—It is our opinion that this question, which is of great importance, has not been adequately

nor fairly dealt with in the majority report. The publications of the Committee (Numbers 5, 18, and 20) which describe existing industrial medical services fail, in our opinion, to give a true picture of conditions as they exist throughout the country. For each of these favorable reports many instances could be cited of industrial medical services where the results have been exceedingly unfavorable. These are types of "contract practice" which have been a source of controversy for many years. The Judicial Council of the American Medical Association defines "contract practice" as follows:

> "By the term 'contract practice' as applied to medicine, is meant the carrying out of an agreement between a physician or group of physicians, as principals or agents, and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or for a fixed rate per capita."

It should be remembered that the medical profession does not object to contract practice *per se* but only to the unethical practices which may attend that method of rendering medical services. There are numerous conditions under which it may be ethical for physicians to enter into contracts to furnish medical care. In isolated mining or lumbering camps medical service can be had only by entering into contract with some physician. Under workmen's compensation laws in some states employers and insurance companies are compelled to provide medical care in such a way that it can be secured only by some form of contract. This came about because workmen's compensation laws in most states were written without regard to the character of medical service under such laws. Defects in the laws are gradually being corrected to provide for a better quality of medical service. Another type of contract practice which cannot be considered unethical is that in isolated communities or sparsely settled rural districts where medical service can be secured only by contracting with a physician to pay part or all of his compensation.

Contracts must be considered unethical and injurious both to the public and to the physician when any of the following features prevail: (1) When there is solicitation of patients, either directly or indirectly. (2) When there is competition and underbidding to secure the contract. (3) When the com-

pensation is inadequate to secure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of physicians is prevented. (6) When the contract because of any of its provisions or practical results is contrary to sound public policy.

Contract practice has been in existence in the United States for many years and lately under the influence of poor economic conditions and the pressure of promoters is becoming widespread. Its chief features are summarized as follows by R. G. Leland: *

(1) Took its origin largely from necessity (isolated conditions); (2) has been legalized in certain places by state statute; (3) under certain conditions and in some forms is both ethical and legitimate; (4) in general, has become highly commercialized and competitive; (5) is largely limited to the pay-roll class; (6) does not, in most cases, extend its provisions to women and children; (7) confines itself, almost without exception, to curative medicine and does not include preventive measures; (8) shows no interest in public or individual welfare; (9) furnishes medical care which is often inferior in character; (10) in many instances is characterized by underbidding, subletting, misrepresentation and racketeering; (11) is economically unsound in many of its present forms; (12) is essentially sickness insurance, usually not supervised or regulated; (13) is often used by the operators thereof to influence legislation in favor of extension of the plan; (14) in many of its present forms, lowers the confidence of both individual and the public in the medical profession; (15) has some features that deserve refinement and extension and others that are unethical and dangerous and should be abolished.

So many abuses have always attended nearly every form of contract practice that the minority is willing to recommend it only when the objectionable features named above can be eliminated.

One of the strongest objections to industrial medical services, mutual benefit associations, so-called health and hospital associations, and other forms of contract practice is that there has been found no means of preventing destructive competition between individuals or groups concerned with these movements. This injects a type of commercialism into medical practice which is harmful to the public and the medical professions and results in inferior quality of medical service.

One of the pernicious effects of contract practice schemes is

* *Journal of the American Medical Association*, March 5, 1932, Vol. 98, pp. 808-15.

that each of them stimulates the launching of other similar schemes until there are many in the field competing with each other. The first may have safeguards against many of the abuses of contract practice, but as new ones are formed the barriers are gradually broken down in order to secure business.

There are general objections to all such methods of furnishing medical care which have been pointed out by representatives of organized labor. They are essentially paternalistic in their operation, giving to the management of industries an increased control over their employees. The intrusion of the company employed doctor into intimate family relationships is objectionable. Privacy and the personal relationship which should exist between patient and physician are broken down. The records of the patient's illness are in the files at the disposal of the company officials. Free choice of physician is absent; coercion is inevitable. Fear of loss of his job compels the employee's consent to the plan and to the doctor furnished by the company.

It is the belief of the minority group that the majority report has presented this entire question in a distorted manner. The evils of contract practice are widespread and pernicious. The studies published by the Committee show only the favorable aspects. They were selected because they were considered the most favorable examples of this type of practice in the United States. For each of these plans a score of the opposite kind can be found. The evils are inherent in the system although they may be minimized when a high grade personnel is found either among employees or medical group, or both.

Any method of furnishing medical care which degrades the medical profession through unfair competition or inadequate compensation, or which breaks down its ethical standards or furnishes inferior medical service, must be condemned. It is hardly open to doubt that contract practice, as usually carried on, is such a method.

Industrial medicine as it operates under workmen's compensation laws is further discussed below under "Group Practice."

1D. Utilization of Subsidiary Personnel.—This recommendation is nothing new in medical practice. It has already developed along many lines through the initiative of the medical, dental, and nursing professions. We need cite only the

widespread employment of technicians in clinical laboratories, the use of dental technicians and hygienists both for laboratory and clinical work, and the extension of nursing service. In radiological departments in hospitals, clinics, and private practice important duties have been assigned to technicians, and their services are being widely utilized. Even in those fields specifically mentioned by the majority report there have already occurred many advances in the directions recommended. We wish to add a word of caution relative to the dangers involved in permitting non-medical technicians to assume the duties which only physicians should undertake. There is constant temptation in many fields to permit technicians to perform duties entirely unjustified by their knowledge and training. Deterioration of service invariably results from such practice.

1E. Private Group Clinics.—We believe the establishment of such clinics is in line of progress when they are a natural outgrowth of local conditions. It is the belief of the minority group that the majority report gives far too much importance to the value of this type of medical practice. That it has accomplished generally or can ever accomplish what is there claimed for it is open to grave doubt. There is nothing in our own experience nor have we been able to find anything in the Committee's studies to lead us to conclude that group practice can furnish in general better or cheaper medical care than we have at present. In cities above 100,000 in population the multiplication of groups results in duplication of laboratories, expensive equipment, and overhead charges which make the system not less but more expensive than the present method. It usually results not in fewer specialists but more, because each group feels that it must have a representative of each important specialty. Even if it were possible to preserve the personal relationship of physician and patient in group practice, which is admittedly difficult, the method has only limited applicability. We wish to call attention to the fact that the studies published by the Committee on "Private Group Clinics" were far too few in number to constitute a safe base upon which to erect so large a structure as is proposed. This is especially true since no evidence is produced to indicate lower costs to patients. The studies of the Committee which show

40 per cent overhead in the practice of private physicians and 15 to 25 per cent for groups fail to tell the whole story. It must be remembered that groups usually offer only partial service and that when full domiciliary care is offered it is often provided through young and inexperienced doctors on a low salary. Costs can always be reduced through a restricted or inferior service. The most important discrepancy in conclusions drawn from the above studies arises from failure to consider the fact that multiplication of clinics or groups in large communities results in provision of expensive equipment far beyond the needs of the community. It serves no good purpose to reduce overhead in individual clinics if the total cost to the community is increased through duplication of plants.

The establishment of groups within recent years in many cities throughout the United States to treat patients under workmen's compensation laws or under contracts made with employers or groups of laymen has resulted in many abuses. Such groups are now in competition with each other, many of them openly soliciting patients through paid agents, many of them controlled by laymen and most of them constantly trying to keep down the cost of operation by employing physicians of inferior ability. Such groups, now scattered all over the United States, are rapidly resulting in the commercialization of medicine and the destruction of professional standards. Under such a system the tendency is to reduce medicine to the status of a competitive business instead of a profession with high ethical standards.

It is not our contention that all group practice has the above results but only that many groups have already been formed to practice under the commercial arrangements indicated. It is important in judging this question to give attention not only to those successful and favorable experiments in group practice cited in the majority report but also to take account of the scores of clinics which have failed and of the large numbers which are at present engaged in a type of practice inimical to every fine tradition of medicine.

Other Disadvantages to the Physician in Group Practice.—Except for the heads of the group, freedom of action is restricted in respect to vacations, study, travel, attendance upon scientific meetings, and even publication of medical articles, by

the will of the chief or chiefs of the clinic. It is contended by proponents of group practice that the physician can advance in professional knowledge more rapidly if he is assured of opportunities for study and is relieved of financial worries by the group, than is possible in private practice. It was pointed out above that only the chiefs of a clinic have freedom to advance along lines of their own choice. Subordinates are not permitted to pursue any course contrary to the general policies of the clinic. It is also very doubtful if men placed on a secure financial footing by a group contribute any more to progress than do those who are impelled to their best work under the stimulation of individual competition, scientific ambition, and initiative. The income of members of a group, except that of the owner or owners, while fairly stable, is comparatively static. When a salaried employee advances in salary to a point no longer profitable to the clinic, his income remains fixed. He then has the choice of waiting until someone ahead of him, whose place he can fill, dies, or of leaving the clinic and starting to build a practice at a time when he should be reaping the rewards of experience and ability.

The plans advocated in the majority report involving groups made up of general practitioners and specialists are theoretically attractive but thoroughly impractical. We are still far away from the time when the general practitioner will be accepted by a group of specialists as the correlator of their work.

We wish to make it clear that the above discussion of group practice does not refer to the association of physicians upon the staffs of hospitals nor their contact and consultation in clinics.

Groups of specialists as distinctive organizations are very valuable for diagnosing or treating difficult or complicated cases but for the 85 per cent of illnesses which make up the family doctor's practice better service can be given by the individual doctor in his own office than in a clinic, and at less cost.

It should be remembered that medical groups are subject to financial failure, just as are other business ventures. This has happened repeatedly and is not prevented by having a lay business manager in charge of finances. In periods of economic depression the group with its large overhead, first cuts salaries, then discharges employees, both professional and lay, and

finally may be forced to close. A frequent cause of failure and disruption of clinics or groups is the death or disability of some able man or men about whom the clinic has been built. When a group is forced to close, the physicians must seek employment in some other group or attempt private practice. The latter is usually very difficult because men in a group usually have little personal following and may have little training to practice general medicine. It should be remembered that patients who go to a clinic are the patients of the clinic and not of any individual doctor. Failure of a group may also have a very injurious effect upon the medical care of the community which is more or less dependent upon it. The private practice of medicine is likely to be a much more stable system, year in and year out, than any system based upon groups. When hard times come and the clinic must keep up its prices to meet its overhead, the private practitioner simply continues to care for his clientele and, with the rest of the community, takes his chances on receiving his pay.

The minority recognizes the advantage of group practice under certain conditions, especially in communities where practically all of the physicians can be joined in one, or at the most, in two groups. It does not believe that group practice offers any real solution to the problems of the cost of medical care except under very restricted conditions. The dangers of group practice are already apparent and the advantages either to the medical profession or to the public are limited.

1F. Pay Clinics.—We approve the development of pay clinics when they are under the management and control of physicians and are conducted on a high ethical plane and are needed to meet a situation. The same ethical considerations should prevail in the relations of clinic and patient as are operative between the private physician and his patient. There is no magic in the name "clinic" that can make it ethical for its agents to solicit patients in its name when it is considered unethical for a physician to do so as an individual. The traditions of the medical profession are strongly opposed to advertising and to solicitation of patients. If the ethics of the profession are broken down at this point, inroads will soon be made at other points, and the profession of medicine will degenerate into a competitive business without professional ideals.

When clinics are owned and controlled by laymen, the evils are accentuated. Clinics so owned or controlled result in the exploitation of the public and the medical professions and in an inferior quality of medical service or an increase in the costs of medical care, or both. When the middleman enters into the picture, the costs of medical care are always increased and quality is sacrificed. This is true whether the middleman is a layman or a corporation running a clinic, or an insurance company which must charge costs of operation to the patient.

1J. County Medical Society Clinics.—The subject is dismissed in the majority report as of little or no importance. The minority believes that this is an important development which may be very valuable in solving the problems of medical care. We discuss it among other specific constructive suggestions offered later.

II. GROUP PAYMENT FOR MEDICAL SERVICE

The Committee on the Costs of Medical Care has been in existence for five years and during that time has collected at considerable expense a great body of data. Among these data are extensive comments on insurance medicine as it has developed and is now working out in various countries in Europe, and also in this country. In 1931 Simons and Sinai conducted a study of health insurance for the American Dental Association which the majority report of the Committee summarizes on page 99. One of the statements in their summary is as follows: "Every attempt to apply the principles of voluntary insurance on a large scale has proved to be only a longer or shorter bridge to a compulsory system. Every so-called 'voluntary' system is successful in just about the proportion that it contains compulsory features." Nothing has been made clearer than the fact that voluntary health insurance schemes have everywhere failed. In Europe they have been replaced by compulsory systems which are now under trial. Even in Denmark, where the system is nominally voluntary, there are indirect but very effective means of compulsion. In spite of these facts the majority of the Committee makes definite recom-

mendations that this country adopt the thoroughly discredited method of voluntary insurance. It is admitted in the majority report on page 125 that there are many dangers inherent in the plan. The principal safeguard against these dangers offered by the majority is to tie the voluntary insurance system up with the visionary medical center plan which they have earlier offered as the "keystone" of all medical service. We have tried to show that such a medical center simply substitutes new and greater evils for old.

It seems clear that recommendations for further trial and expansion of voluntary insurance schemes in the United States are entirely inconsistent with the Committee's own findings. To recommend that our own country again experiment with discredited methods of voluntary insurance is simply to ignore all that has been learned by costly experience in many other countries as well as in our own.

Voluntary insurance systems are now in operation in many parts of the United States and are increasing in number and in size. In many places these schemes are being operated in accordance with the plan recommended by the majority of the Committee, that is, by making contracts with organized groups of the medical profession. That they are giving rise to all the evils inherent in contract practice is well known. Wherever they are established there is solicitation of patients, destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the professions. It is clear that all such schemes are contrary to sound public policy and that the shortest road to the commercialization of the practice of medicine is through the supposedly rosy path of insurance.

The careful reader of the majority report will note that not all of those who sign that report are willing to recommend voluntary insurance. Arguments against the voluntary system are forcibly set forth by the dissenters among the majority on page 131.

It seems clear, then, that if we must adopt in this country either of the methods tried out in Europe, the sensible and logical plan would be to adopt the method to which European countries have come through experience, that is, a compulsory plan under governmental control.

Before doing so, however, we should carefully examine this plan as it operates in Europe at present and face the objections to it. It should be remembered that compulsory systems of health insurance in European countries are still under trial. There is still no convincing proof that under these systems the costs of medical care have been reduced nor that the new evils to which they give rise are preferable to those which they are supposed to abate. The statement that most of the physicians in England prefer not to go back to the system under which they practiced before is not convincing because the system under which they practiced before was one of widespread voluntary insurance.

The objections to compulsory health insurance are almost as compelling to this minority group as are those to voluntary insurance. The operation of every form of insurance practice up to the present time has resulted in a vast amount of competitive effort on the part of practitioner groups, hospitals, and lay controlled organizations. Such competition tends to lower the standards of medical care, degrade the medical personnel, and make medical care a business rather than a profession. Proof of this is at hand in our own experience in this country with the only compulsory system with which we have yet had to deal, workmen's compensation insurance. The results named above are prevalent in many states. This is the rule to which there are a few notable exceptions. Under workmen's compensation, groups are soliciting contracts, often through paid lay promoters; laymen are organizing clinics and hiring doctors to do the work; standards of practice are being lowered; able physicians outside of the groups are being pushed to the wall; the patient is coerced by his employer to go to a certain clinic; and the physician is largely under the control of the insurance companies. These are not visionary fears of what may happen but a true picture of widespread evils attending insurance practice. We should need no better example of what must happen to medical care if compulsory insurance is extended to families.

There is one aspect of any system of insurance which should be kept in mind by all students of this question, namely, that the total cost of medical care is usually increased when it is paid for through insurance. There are two reasons for this.

First, the cost of operation of the insurance plan must be added to the cost of medical care. The majority report recognizes this by the following statement on page 50: "The participation of insurance companies in the forms of insurance against the costs of medical care which are recommended in this report would, the Committee believes, tend to increase the costs and not to improve the service." The majority report, therefore, approves of insurance but disapproves of insurance companies. This means, of course, that the majority report favors some form of insurance through a non-profit organization. The minority agrees that this principle should always govern in any plan of contract practice that may be necessary to meet the needs in a particular situation. The patient's fees will then be available for the costs of medical care, aside from the necessary costs of administration. The second reason for the increased cost of medical care under insurance systems arises from a fact which has been thoroughly demonstrated, that is, the number of persons sick and the number of days sickness per capita always increase under any system of insurance. This is shown to be true for European countries by Simons and Sinai and has been demonstrated in relatively small health insurance projects in this country. "Contrary to all predictions, the most startling fact about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually and the continuously increasing duration of such sickness. Various studies in the United States seem to show that the average recorded sickness per individual is from seven to nine days per year. It is nearly twice that amount among the insured population of Great Britain and Germany, and has practically doubled in both countries since the installation of insurance." *

We are not here attempting to marshal all of the facts or arguments that can be used against health insurance. Innumerable articles have been written on the subject. No absolute judgment is possible at the present time with regard to what place, if any, insurance should finally have in helping people to pay for medical care. We have tried only to show here that there are great dangers and evils in insurance practice which

* *The Way of Health Insurance.* A. M. Simons and Nathan Sinai. Page 157.

must be set over against the advantages of distributing the costs of medical care by this method and which, it seems to us, the majority report has minimized. The dangers are especially directed at the continued well-being and progress of the medical professions, which, after all, are the ones most concerned in maintaining a high grade of medical service. It ought to be remembered that compulsory insurance will necessarily be subject to political control and that such control will inevitably destroy professional morale and ideals in medicine. Since a qualified and untrammelled medical profession is the only agency through which scientific medicine can be applied for the benefit of the people, it follows that any plan which destroys professional morale will bring disaster to the public. One of the conclusions of Simons and Sinai * is of especial significance in this connection. "While the statement might be disputed by insurance societies, a comparative study of many insurance systems seems to justify the conclusion that the evils of insurance decrease in proportion to the degree that responsibilities, with accompanying powers and duties, are intrusted to the medical professions." This statement is both a challenge to the medical profession and a warning to those who, without proper consideration of that profession, are willing to recommend the adoption of various new plans for the care of the sick.

It is our conviction that the Committee on the Costs of Medical Care would have served its stated purposes and the cause of medical progress and the people's health much better if it had taken a strong stand against all of those methods of caring for the sick which have in them the dangers and evils of "contract practice." By doing so they would have come to the assistance of the medical profession in a battle against forces which threaten to destroy its ideals, disrupt its organizations and completely commercialize its practice, and which are at the same time opposed to the public welfare. The medical profession is now in many parts of the country extending and perfecting plans through which it can offer to the people in a more systematic way the services of *all* the physicians of each community at prices which all the people can afford. It is only

* *Loc. cit.*, p. 206-207.

by including *all* of the members of the medical profession of a community that the abuses under insurance systems may be avoided. The nature of some of the plans is indicated under the minority recommendations below.*

III. RECOMMENDATIONS OF THE MINORITY

The minority group in offering the following recommendations has tried to keep in mind the main object which called this Committee together, namely to find some solution for the problem of furnishing good medical care to all the people at prices which they can afford. We have no delusions that our recommendations, even if fully put into effect, will solve all the problems of medical care. We have tried to approach the problem from a practical standpoint and to suggest progressive changes in the present system rather than to offer new methods based largely on theory and revolutionary in their practical application. We believe that our view-point is divergent from that of the majority in this respect. We are not opposed to progress nor to the adoption of new procedures. We are especially concerned, however, that new procedures be based upon sound experience and that in adopting them we do not lose the values that have been accumulated through the centuries. It is true in medicine as in all other fields of human experience that the soundest and most lasting progress is brought about slowly and step by step. Medical practice in the United States is progressing in this manner. We believe this to be the truly scientific method. We are loath to adopt revolutionary theories, however attractive they may seem, which may have within them the seeds of more harm than good.

It has been stated in the majority report of this Committee that we must plan twenty to fifty years in advance. We doubt our wisdom to do this. If society changes as rapidly in the next fifty years as in the past fifty, it seems presumptuous to assume that we can foresee conditions or needs sufficiently clearly to plan so far in advance. It is not too soon, however,

* *Dissenting Statement by Members of the Minority Group.*—We are not in entire agreement with the above condemnation of compulsory health insurance. We believe it may be possible to guard against many of the evils of the system, and that it is worthy of a trial.—Kirby S. Howlett, Robert Wilson.

to plan for the profession which is to furnish medical care a generation hence. If that profession is to attract young men of ability and high ideals, the great traditions of medicine must be preserved. We repeat here what we have stated earlier in this report that reductions in the cost of medical care which are obtained at the cost of degrading and demoralizing the professions upon which the people must depend for that care are far too costly to be of real value.

In making its recommendations the minority has had constantly in mind the first postulate set down at the beginning of Chapter II in the majority report to which we unreservedly subscribe. It is as follows: "The plan must safeguard the quality of medical service and preserve the essential personal relation between patient and physician."

The term "personal relationship" used so frequently throughout the Committee's publications and in the final report conveys but a vague meaning as to its essential elements and the reasons for its emphasis.

By personal relationship is meant that bond of sympathy and interest in the patient's welfare on the part of the physician, confidence in the ability, integrity and discretion of the physician on the part of the patient, and mutual regard on the part of each for the other which cause the patient to disclose for the purpose of diagnosis and treatment the most private and confidential information concerning himself and his surroundings when necessary for proper diagnosis and treatment. The character and personality of the physician is a major factor in its development and in process of time and continued contact as patient and physician a friendship and intimacy develop that assumes priestly characteristics on the part of the physician—the characteristics of the confidant and adviser in the most intimate personal and family relationships. All phases of personal and family life are at times closely related to the diagnosis and care of an individual's condition, and economic and financial conditions are often as important in diagnosis and care as physical or mental abnormalities. It is an individual relationship, the product of character and personality and cannot be transferred to a group or fostered by group practice.

It is our belief that the majority report in many of its recommendations for group practice and group purchase and in its emphasis upon what may be called "mass" practice instead of

individual practice has completely lost sight of this primary postulate.

Our recommendations are based upon the conviction that the medical profession is the essential element in the furnishing of medical care. Its influence should be upheld and strengthened and every assistance given to it to maintain its high professional standards. They are based upon the further conviction that the general practitioner is the most important factor in the medical profession and that he can function effectively only through the maintenance of private medical practice.

1. Government and Community Participation in Medical Care.—Many of the difficulties of the medical profession and a part of the problems of the costs of medical care to the moderate income groups would disappear if local and national governments and communities in general were properly fulfilling their obligations. On the one hand, there is failure to assume the full care of the indigent and, on the other, there is usurpation of the field which should be reserved entirely for private practice.

Recommendation 1.—The minority recommends that government competition in the practice of medicine be discontinued and that its activities be restricted (a) to the care of the indigent and of those patients with diseases which can be cared for only in governmental institutions; (b) to the promotion of public health; (c) to the support of the medical departments of the Army and Navy, Coast and Geodetic Survey, and other government services which cannot because of their nature or location be served by the general medical profession; and (d) to the care of veterans suffering from *bona fide* service-connected disabilities and diseases, except in the case of tuberculosis and nervous and mental diseases.

We stated early in this minority report that we heartily endorse the recommendations of the Committee which deal with strengthening of public health services. We emphasize especially the following points: (1) The need for more adequate training of medical students in public health matters; (2) the elimination of politics from public health administration; (3) improved standards in public health services to make them

more attractive to able men; tenure of position should be more secure and remuneration should be increased.

It is our belief that government should not extend its activities into those fields which can be effectively covered by the private practice of medicine.

We wish especially to emphasize our recommendations that the governmental care of veterans for general medical and surgical conditions be restricted to *bona fide* service-connected disabilities and diseases. The supply by the government of hospital facilities necessary to care for the more than four million veterans with their increasing disabilities as they advance in age will constitute a colossal waste. Last year from 25 to 40 per cent of the beds in civilian hospitals throughout the United States were empty. There is good evidence to show that all veterans can be taken care of in existing hospitals if non-service-connected disabilities are treated in civilian hospitals. The treatment of veterans by the government for non-service-connected disabilities has resulted in hardship to the medical profession by withdrawing many patients from private practice. The waste incident to the transportation of veterans back and forth between their homes and government hospitals is enormous. It is advantageous to the veteran to be treated near his own home by the physician of his own choice. This is especially important in acutely urgent diseases. We believe that the law providing for government treatment of non-service-connected disabilities should be repealed.

2. Care of the Indigent Sick and Injured.—It should be recognized that it is the duty of the state to give complete and adequate medical care to the indigent. One of the greatest burdens on the medical profession today is the care of the poor. Many communities provide hospital care for the indigent when they need it, although even this is not fully provided for in most communities. The full burden of the professional care of indigents not only in their homes but also in hospitals and clinics is thrown upon the medical profession. Attempts have been made to estimate the money value of the free service performed by the doctors of the country each year. It is practically impossible to arrive at anything definite by such attempts. It is known, however, that the medical profession has always performed this service without pay and few communities have

ever recognized any obligation to relieve them from it. It is obviously a burden which should be borne by the entire community and not by the medical profession alone. The doctor should bear his share like any other citizen through payment of taxes and support of the local community chest and other charitable agencies, but he should be paid by the community for his professional services to the indigent. The only exception to this should be where he renders service in an institution in which he receives his compensation in added prestige and experience. The community should also bear the total cost of hospitalization, nursing, etc., of every indigent person.

Recommendation 2.—The minority recommends that government care of the indigent be expanded with the ultimate object of relieving the medical profession of this burden.

If such a plan were made effective, its results would be far-reaching. The income of physicians would be increased. The young doctors would benefit especially because it is always in the first years of practice that a doctor treats the largest percentage of charity patients. Such a plan effectively carried out, would have a definite effect upon the cost of medical care to those who can pay for it. It would result in reduction of cost of hospitalization of pay patients because at present the patient must pay not only for his own care but in addition a certain proportion of the cost of the care of the indigent. It would be much more reasonable to determine whether or not communities can and will pay for the cost of medical care for their indigents, who are logically a charge against it, before plans are tried to compel the community to bear the costs of sickness of those who have incomes.*

3. Coordination and Control of Medical Services.—This is one of the recommendations of the majority with which we are in general accord. We wish to emphasize further the importance of putting these measures into effect in the immediate future. Much waste can be eliminated in our present system by the coordination of our present agencies and methods. The minority group recommends as a permanent coordinating body

* *Additional Statement by Member of the Minority Group.*—While accepting in general the principle of the state responsibility for the indigent, I cannot regard the responsibility as exclusive, since by such a policy the economic, social, and spiritual benefits to the public derived from private and voluntary philanthropy and charity would be endangered.—A. M. Schwitalla.

the agencies listed in the majority report. In order to initiate a progressive program for cities, counties, or states the appropriate medical, dental, and pharmaceutical societies and hospital associations should appoint committees to ascertain the facts regarding the provision of medical service; to study the various possibilities for extending the service; and to prepare local or state plans accordingly. We agree with the majority that "to provide a full and balanced view of problems and needs, to contribute administrative experience and to give added weight to recommendations such committees should include informed persons as associate members or should establish cooperative relations with representatives of appropriate public organizations such as community chests. . . . . The community may properly look to its physicians, dentists, and other persons who have a full-time interest in the problems of medical economics to furnish dynamic leadership in community planning." We wish to emphasize the fact that medical and dental professions and hospital associations have already in many localities initiated movements intended to coordinate medical service. The success of these movements is likely to be in direct proportion to the degree of interest exhibited by the local professional organizations. They must increasingly assume responsibility for initiation and guidance of efforts in this direction.

These first three recommendations seem to us the first steps that should be taken in dealing with this problem. Their widespread adoption would eliminate so much waste from our present system that the problem would immediately take new and less urgent aspects.

4. Restoration of the General Practitioner to the Central Place in Medical Practice.—The next logical step after the three named above is further elimination of waste by increasing the efficiency and extending the field of the general practitioner of medicine.

Recommendation 4.—The minority recommends that united attempts be made to restore the general practitioner to the central place in medical practice.

This, of course, is quite the opposite of the majority's recommendations for concentrating medical practice in groups and medical centers. The majority report of the Committee recog-

nizes and emphasizes the extremely personal nature of medical practice. In the Summary Volume, Chapter XXIII, is found the following statement: "It (medical care) is also a personal service involving individual relationships between a medical practitioner and a patient. . . . . The personal nature of disease and of medical care is the foundation upon which the economic organization of the past has been constructed, and must be the basis for expansion or reconstruction of the future. To ignore or deny the significance of this personal element in the economic organization of medical care would be as absurd as to overlook the laws of mechanics in the construction of a bridge." We have no doubt of the truth of the above statement nor of its fundamental importance. It contains the reason why we are opposed to all forms of medical practice which make it difficult or impossible to maintain the personal relationship of physician and patient. This is one reason for our insistence that the general practitioner must be kept in a central and important place in medical practice. Neither do we agree with the majority that savings in the cost of medical care are to be made by eliminating the general practitioner or submerging him in a group. Experience has taught us that the opposite is true. In a group the general practitioner tends to disappear. The great majority of illnesses and injuries (about 85 per cent) are of such nature that they can be treated efficiently by any able general practitioner with very simple equipment. In fact, the general practitioner does not need elaborate apparatus of any kind. His most important items of expense are his means of transportation and his rent. Neither of these can be greatly affected by combinations of general practitioners in groups. The organization of a group of 15 to 25 men results in increase in expense to the community, since the group must have complete apparatus for all branches of medicine whereas before they were joined in the group the entire 15 to 25 utilized the X-ray and other laboratories already established in the community. Theoretically there seems to be economy in group practice but practically this is true, as has already been pointed out, only in small communities where only one or two groups are necessary for the entire community.

Efforts, then, should be directed not to the elimination of the general practitioner but to the preparation of students in medi-

cal schools better to fill the important place that he has always occupied. The primary object of medical education should be to develop general practitioners. It is not that medical courses must become longer and more difficult but that the emphasis must be changed. The general practitioner is quite capable of taking over many of the procedures now assumed by specialists and should do so. It is not only in the field of diagnosis and therapy that the emphasis is changing, but it is now recognized that the general practitioner has a wide field in the prevention of disease. Instruction in this field should be improved in professional schools. In a word the general practitioner must be equipped to render good medical service to the families in which he becomes the trusted medical adviser.

Along with a change in the basic education of general practitioners, must go better training and better control of specialists. As has already been stated specialism has added much to medical progress. It needs now better control in order to fit it into our present life. Among specialists, group practice works to advantage and will eliminate some sources of waste.

5. Corporate Practice of Medicine.—A number of corporations have been formed in different parts of the United States for the purpose of selling the services of physicians to the public. Many of them include some type of insurance scheme. It is our belief that these schemes of laymen to exploit the medical profession and the public are a logical outcome of the many insurance schemes which have preceded them in this country and abroad. They are simply a further step in the commercialization of medicine. Their nature is clearly shown by the statement of one of them concerning the distribution of each dollar paid for medical care. Of each dollar, 45 cents is set aside for medical care not including hospital charges; 12.5 cents is for hospitalization; the remaining 42.5 cents goes to the company.

Some universities and some hospitals have capitalized the reputations and services of their professors in medicine or their staffs, charging fees commensurate with the ability of patients to pay for the professional services rendered by this essential personnel. The excess of fees collected above the salaries paid is a direct profit to the institutions and is derived from a personal service which the law permits to be rendered

only by an individual who is duly licensed to deliver and charge for such service. In some hospitals, the physician renders his services without salary or other emolument except the prestige of a staff position.

This minority group is opposed to all such schemes and offers the following recommendation:

Recommendation 5.—The minority recommends that the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed as being economically wasteful, inimical to a continued and sustained high quality of medical care, or unfair exploitation of the medical profession.

6. Trial of New Methods.—Many experiments are being tried at various places throughout this country to assist the people in dealing with the economic aspects of sickness.

Recommendation 6.—The minority recommends that careful trial be given to methods which can rightly be fitted into our present institutions and agencies without interfering with the fundamentals of medical practice.

There are many plans developing at present which seem to us proper evolutionary developments and have the great advantage of being immediately practicable. They embody no revolutionary changes which might interfere with medical progress in the future. We note that the majority report minimizes the value of some such plans because they are only "palliative." We look upon this as an argument in their favor. Objection to so-called "palliatives," which with other like measures may relieve conditions so that no radical procedure is needed, would be similar to the surgeon refusing minor surgical or medical treatment on the ground that it might prevent a major operation.

Plan for Treatment of Chronic Diseases.—We call attention to a plan for treatment of chronic diseases which tends to improve quality of service, regulates the expense of treatment, and distributes the payments over a period of time. This plan is applicable under individual or group practice and has no objectionable features.

Under the system of charge per visit many chronic diseases do not receive adequate care. There are two major reasons: (1) indifference or ignorance on the part of the patient, and (2) economic reasons.

Indifference.—The development of chronic diseases is often so insidious as to result in a precarious condition of the patient before his trouble is brought to his attention. He is faithful in attendance and in following instructions until, in his own opinion, his trouble is cured or sufficiently relieved to need no further attention, and he postpones or stops coming for periodical check-up, either because he feels it not needed or because he objects to paying for visits which only assure him he is getting along properly or needs but minor changes in his routine. He therefore ceases to be under observation and control and soon returns to his former precarious condition. The treatment must then be carried out all over again, with its loss of time, increased expense, and advancement of the pathological condition. Often the patient does not return to the former physician and the necessary process of diagnosis and inventory must be repeated at additional cost and loss of opportunity to the patient. With continuous complete service for chronic diseases paid for on a yearly basis the temptation to relax in care would be largely removed.

Economic Reasons.—Only a small portion of the service necessary in the care of chronic diseases can be paid for by the majority of the people under the fee-per-visit system of charging, and one of the following conditions results: (a) The patient discontinues his treatment because he cannot pay and does not wish charity: (b) the patient continues to receive treatment and runs a bill which he can probably never pay; (c) the physician takes care of him as a charity patient after he has been charged the amount he can afford; (d) the patient is sent to a dispensary after he can no longer pay his doctor. This situation is bad for both patient and doctor, since the former needs continuous care by the same doctor and the latter desires to study and treat the entire course of a disease and not an isolated incident in it.

A satisfactory solution of this problem is found in the application of the following philosophy of practice. The doctor has knowledge and skill for sale. If he desires to treat patients with certain diseases, he must familiarize himself with the vagaries of these diseases and must possess the necessary equipment and skill in its use to perform all the necessary service. If the essential knowledge and skill is beyond the capacity of one individual then the one desiring to give the

major part of the service must ally himself with others giving the needed supplementary services, and must pay them for this service, charging the amounts so paid to his office expenses.

No patient should be charged separately for a visit or any particular part of the service, but for all of it, no matter what it comprises. Since chronic diseases need continuous supervision of the patient by the doctor the application of this principle requires that chronic diseases be treated for an inclusive fee to cover complete medical service for that disease for a definite period of time. This fee should be assessed on a sliding scale in accordance with the patient's financial circumstances, with a minimum just above the charity level and a maximum comparable to the fees now paid by the wealthy. This fee should bear no relation to the number of visits or the type of service rendered. Practice under this plan has been carried on since 1929 in The Asthma and Hay Fever Clinic in Cleveland with satisfaction both to doctors and patients.*

Payment under this plan can be made in advance or on a series of deferred payments as agreed to by the patient and physician. The former knows what his year's care will cost and need not worry over the number of visits or "extra" services. The latter has agreed to and knows just what he is to receive and when he will receive it. Relations between patient and physician are not subjected to any strain or reserve on economic grounds under this plan.

Another plan that is being tried extensively is the grouping of physicians' offices in or around a hospital. We agree with the statement in the Summary Volume in Chapter XXIV that "the centering of medical service in the hospital, which already represents an important concentration of capital investment and professional personnel, would appear to have practical advantages for physicians, hospitals, and patients." It is opposed to the principles we have laid down, however, for the hospital to control medical practice or to enter into the practice of medicine in any of its branches as an institution.

A caution that is necessary at this point concerns the danger of over hospitalization when all the medical activities are centered around a hospital. A further caution is necessary

* *The Bulletin of the American Medical Association*, June, 1931.

with regard to establishment of hospitals in localities where there is insufficient or unqualified personnel and where a hospital is not actually needed. The merit of a hospital depends upon the ability of the professional personnel who are charged with its work. It is not brick and mortar but men who make the value of an institution.

7. Development by State or County Medical Societies of Plans for Medical Care.—The recommendations we have offered up to this point are concerned with the elimination of waste, the abatement or avoidance of evident evils in present practice, and improvement in the quality of medical care. We have already set forth our objections to the majority's recommendations for adoption of insurance systems. We tried to make it plain that we are not opposed to insurance but only to the abuses and evils that have practically always accompanied insurance medicine.

Medical societies in various parts of the United States have been giving careful study to the question of the possibility of distributing the costs of medical care and at the same time avoiding the evils of insurance systems.

This minority group agrees that any plan for the distribution of medical costs must have the following safeguards:

1. It must be under the control of the medical profession. (A "Grievance Board" to settle disputes, having lay representation, is permissible and desirable).
2. It must guarantee not only nominal but actual free choice of physician.
3. It must include all, or a large majority of the members of the county medical society.
4. The funds must be administered on a non-profit basis.
5. It should provide for direct payment by the patient of a certain minimum amount, the common fund providing only that portion beyond the patient's means.
6. It should make adequate provision for community care of the indigent.
7. It must be entirely separate from any plan providing for cash benefits.
8. It must not require certification of disability by the physician treating the disease or injury.

This group recognizes the value of trial of plans based upon

the above principles by county medical societies. We believe that the county society, approved by and under the supervision of the state and national societies, is the proper unit of organization to attempt such experiments. Report will be found in the committee's findings of various county societies in Iowa which have been experimenting with caring for the indigent as a county society project. Our reasons for favoring thorough trial of the county society plan for furnishing complete medical care are as follows:

1. It places responsibility for the medical care of the entire community upon the organized physicians of the community.
2. It places medical care under the control of the organized profession instead of in the hands of lay-corporations, insurance companies, etc.
3. It places responsibility for the quality of service directly upon the organized profession. It is in fact the only plan which guarantees quality of service and makes it the only basis of competition.
4. It removes the possibility of unethical competition because it includes all the physicians of the community and fixes a fee schedule.
5. Solicitation of patients, underbidding for contracts and other evils of the usual insurance plans are eliminated.
6. Freedom of choice of physician is assured and the essential personal relationship of physician and patient is thereby preserved.
7. It is the only plan which includes all classes, from the indigent to the wealthy.
8. It is adaptable to every locality, both urban and rural.
9. It provides for a minimum cost of administration by operating on a non-profit basis.
10. It provides for payment, by every patient with income, of a certain minimum amount before the insurance is in operation. The minimum rises with the patient's income. This provision alone will operate to avoid many abuses in all other types of insurance practice.
11. It provides for means of certification of disability separate from the attending physician.
12. Cash benefits do not form a part of the plan.

The main objections urged against the plan are that it places too much power in the hands of the organized medical

profession, and that county medical organizations will be too lethargic to put the plan into operation.

It is the opinion of this group that it is much better to lodge power in the hands of the professions which are trained to furnish medical care than in the hands of lay corporations. This is especially true when, under the proposed plan, responsibility can be definitely placed on the organized professions for the quality of care furnished. The plan provides for settlement of individual disagreements or complaints by a "Grievance Board" with adequate lay representation. The objection to the plan on the grounds of lethargy of medical societies should not have great weight. Many medical societies are very active in promoting means for better care of the people of their communities. It is our belief that when the proposed plan has been in successful operation for a short time its advance will be spontaneous and widespread.

It is true that the plan in some essential respects is new, but it is based upon past experience. It is an attempt to distribute the costs of medical care by utilizing the good in insurance plans and avoiding their dangers and evils.

IV. CONCLUSION

The problem of the payment of the various expenses that accompany disease and injury has arisen as a result of developments in the medical field, on the one hand, and of complex changes in the economic and social order, on the other.

Within the past fifty years, as the Chairman of the Committee has emphasized in his introduction, revolutionary changes have taken place in the practice of medicine because of various important discoveries in the causation, treatment, and prevention of disease. Within that time bacteriology, serology, and the x-ray have developed; hospitals have grown to enormous proportions; nursing has come to occupy a place not formerly thought necessary; specialization is now an important part of medical practice; medical education occupies a far longer time and is much more expensive than formerly; and apparatus for the diagnosis and treatment of disease now requires the investment of a large amount of capital.

Such changes in themselves would have increased the costs of medical care, but the problem has been rendered much more complex by the rapidly changing conditions in society and industry. The population of the United States has changed in a comparatively short time from one predominantly rural to one in which fifty per cent of the people live in cities. This means that a much greater percentage of the people is now employed in industries than was formerly the case. Along with this urbanization and industrialization, there have developed radical changes in the standards of living. The luxuries of the late nineties are now necessities of life for great masses of the population. All of these changes, both in the practice of medicine and in society, have operated to cause an increase in the costs of taking care of people when they are sick. There is little doubt that the changes are desirable but it is obvious that they increase the costs of medical care.

It is plain, therefore, that many of the problems which are under discussion are the general problems of a transitional stage in social development and are not peculiar to medicine or medical care. Their solution must depend upon far-reaching social and economic adjustments. They are analogous to the problems which caused great social and political unrest in the last decade of the last century and which were not settled until there was a general increase in wages to compensate for improvements in the standards of living.

It does not seem probable to this minority group that these complex problems can be solved or necessary social readjustments hastened by the widespread adoption of the recommendations of the majority of this Committee for the group practice of medicine or group purchase of medical care.

Our understanding of the majority report is that it offers essentially the following type of medical practice in the future: The medical profession is to be formed into large or small groups, preferably large, and these groups are to furnish medical care under some type of contract with groups of laymen, the funds to be furnished by insurance, preferably of the voluntary type. Over against this we offer medical care furnished by the individual physician with the general practitioner in a central place; with groups and clinics organized only where the nature of the situation and character of the per-

sonnel render such organization a natural development; with elimination of waste in our present methods and coordination of all existing agencies; with careful trial of new methods based upon sound experience; and with adoption of insurance methods only when they can be kept under professional control and destructive competition eliminated; all of this through a well organized, untrammelled medical profession true to the great traditions and ethical standards of the past. Centuries of progress in the conquest of disease gives us confidence that the individual and not the group should remain the unit in the practice of medicine.

We wish to emphasize once more in closing our accord with the majority of the Committee in their recommendations for improvements in public health service and in the scope of medical education. We would especially express our appreciation of the great value of the mass of factual data compiled by the staff and so ably summarized in the Summary Volume.

A. C. CHRISTIE,
GEORGE E. FOLLANSBEE,
M. L. HARRIS,
KIRBY S. HOWLETT,
A. C. MORGAN,
A. M. SCHWITALLA,
N. B. VAN ETTEN,
OLIN WEST,
ROBERT WILSON.

MINORITY REPORT NUMBER TWO

BY

HERBERT E. PHILLIPS, D.D.S., AND C. E. RUDOLPH, D.D.S.

The undersigned are in accord with the main position of the majority of the Committee, in that we recognize existing professional and social trends in medical care as brought out by the Committee's studies and believe that these trends necessitate substantial changes in the manner in which medical service is rendered and paid for. There is no doubt in our minds that an increased amount of medical service should and will be rendered through professional organizations rather than by individual practitioners working independently. We also believe that payment for medical service by distributing the costs over groups rather than having it fall upon individuals is a sound principle when applied in such ways as maintain professional standards of service. We are in accord, therefore, with the general recommendations of the majority in favor of group practice and group payment, although we must register dissent from certain specific proposals and certain implications of the majority report which we do not consider justified.

We are, however, in accord with those who signed Minority Report No. 1 in strongly emphasizing the necessity of maintaining professional standards and the position of the general practitioner, and we recognize, as they do, that grave dangers to these standards have developed in the past and will exist particularly during a period of rapid changes in medical service such as we are undoubtedly facing. In our opinion, the most important influence for the maintenance of professional standards is vigorous initiative on the part of the professions themselves. They should, as individuals, and through their professional organizations, recognize frankly the existence of the problems and needs which are brought out by the studies of this Committee and should themselves take steps to deal with them, through initiating or participating in experiments in group practice and group payment. We realize that needs are more acute in some localities than in others and therefore early recognition of these needs should be made. Nothing, in our opinion, would be more deterimental not only to the medi-

cal service of the public, but to the welfare of the professions, than an attitude of opposition or mere aloofness on the part of the professions. We recognize that certain evils that have developed in group practice and in sickness insurance in the past have been chiefly due to lack of professional initiative and control and that with the assumption of initiative and control by the professions at this time these evils will be minimized in the future.

We feel with those signing Minority Report No. 1 that the attitude of the majority is unduly critical of the professions, and that this attitude has developed a bias in some of the statements in their report. We agree also that the investigation of industrial schemes by the Committee almost entirely overlooked their defects, and only the least objectionable and most successful were chosen for study.

We agree with Minority Report No. 1 that the description of the community medical center, which is set forth in the third chapter of the Majority Report as the ultimate goal of development, is Utopian in concept, and involves many details which are too visionary or problematical to justify inclusion in an authoritative report of this kind.

It is to be regretted that the Committee's studies did not include any study of dental group practice. Studies of such groups should have been made both as regards their organization and the quality of their service. The dental profession should initiate experimentation in dental group practice and should encourage cooperative experiments involving physicians and hospital service. Studies of the American Dental Association show that such cooperative participation is on the increase. All such experiments would provide valuable facts as a basis for future development.

We do not consider that voluntary and compulsory sickness insurance should be regarded as in opposition to each other or as unrelated proposals, as seems to be implied in the Majority Report. European experience indicates that methods developed under voluntary insurance have indicated the pattern for compulsory insurance later, and should furnish necessary experience for the United States. Experience thus gained in voluntary insurance, both by the public and the professions, would be an asset if and when certain states contemplate com-

pulsory systems. In certain sections of the United States, voluntary insurance has already developed to a considerable degree. It is true that in these sections certain evils have developed but it is probable that the introduction of compulsory insurance under professional control will eliminate the objectional features. The more the difficulties are eliminated or controlled in the voluntary plan, the less risk of having objectionable features in the subsequent compulsory insurance.

We do not feel that this method of payment need interfere with the highest professional standards nor with the close personal relationship between practitioner and patient.

The studies of the Committee indicate that a large proportion of the population receive incomes, even during prosperous times, so low as to preclude the purchase, under any form of payment, of adequate medical service. This is emphasized by the following quotation from Summary Volume, Chapter XXXIV:

> The significance of the economic barrier between the true need and the current receipt of medical care is especially evidenced by the finding that far greater inadequacies obtain for those of small than those of large means. Just as some people go hungry though the country produces more food than the people can consume; many are inadequately clothed though we manufacture more clothing than we can use; even so millions are sick, hundreds of thousands suffer pain and anguish, and tens of thousands die prematurely for lack of medical care which available personnel and facilities could supply. The tragedy concealed in this conclusion is the more poignant because medical practitioners and institutions are used to only part of their capacity—not because their services are not needed, nor because they are unwilling to serve.

We add to these reasons because fundamentally, as the studies of the committee reveal, the problem of providing medical care is a question of low incomes and the solution depends at least as much upon increasing incomes to a satisfactory standard of living, as upon methods of organizing medical care. We recognize, however, that the ability to purchase medical care on an insurance basis is greater than when the cost falls upon the individual family.

We are in accord with and strongly recommend medical society plans of sickness insurance such as those referred to in Minority Report No. 1, page 179. These would place responsibility on the professions for the maintenance of standards of service and would set up, for a state or a community, agreed

rates of payment so that competition between different professional groups furnishing service or between individual practitioners would be on a basis of quality of care and not on a basis of charges. It is destructive to standards of medical care, in which both the public and the professions have a common interest, if competition exists in such form as to bring about price-cutting and under-bidding for service. We strongly endorse the initiative of such professional bodies as the Milwaukee Medical Society * or the State Medical Society of California in endeavoring to meet their obligations to the public by developing plans of group payment. Such a form of organization of medical service under professional control will set a pattern which will determine the direction of any future development of organized medical care in voluntary or compulsory insurance. Such an opportunity typifies the attitude of the British Medical Association referred to in the quotation on page 118 of the majority report as follows:

> Such a scheme may be compared to a plan submitted by an architect to a householder who wants to extend the house in which he lives, and to introduce all modern improvements. The householder may, on seeing the plan, decide that it would cost too much and that he must put up with his house as it is; or he may make suggestions for the modification of the plan. But the householder knows that if he wants to extend his house he is, as regards essentials, in the hands of the architects and builders.

We fully agree with the statement concerning coordination of medical service contained in Minority Report No. 1, page 172, as quoted from the Committee's report, page 134.

With a full knowledge of the inherent evils of the early competitive systems of medical and dental education, we believe it would be of great value if a national organization were to be formed to study group practice and to define its standards, and suggest that such a plan be sponsored by those bodies that have supported studies of medical and dental education.

During rapid social changes group practice and individual practice are developing side by side, and should develop in cooperation. Conflicts between those dealing in medical care under any auspices will have a disturbing effect on practitioners and a deterimental effect on the public, whom they

* See p. 75 of the Committee's report for a description of the Milwaukee plan.

serve. All of this is against professional traditions of medical care. These methods must meet in service, adjustment must be made so that conflicts may be eliminated, and codes must be adapted to meet changing conditions.

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