distinctive character. Although early American developments in medicine, as well as the development of the hospital, followed European patterns, they took on some unique features.[1] By the nineteenth century the European countries with the greatest influence on the colonies were already highly urbanized, and medical education and practice had taken on a specialized character with a growing separation of general practitioners from hospital doctors and clear distinctions between physicians, surgeons, and apothecaries.[2] But America was frontier country and largely rural, and such distinctions were inappropriate for a population scattered over a vast land area with a low population density.[3] Doctors functioned for the most part as generalists, doing whatever they thought was necessary to meet their responsibilities, and the jealousies and distinctions so important in European medicine did not take root. When the idea of the general voluntary hospital, borrowed from Great Britain, was implemented first in Philadelphia and later in other cities,[4] the doctors who offered their services free to the indigent obtained the privilege of using the hospital to treat their own private patients as well. This pattern, first established under conditions very different from those that now exist, has persisted as the dominant one to this very day and carries along with it certain merits, but also some important disadvantages. For example, despite the far-reaching trend toward specialized medical functions, access to the hospital and complexity of work undertaken by the individual doctor have only a very limited relationship to the length of his training and competence. Even today a vast bulk of the total surgical work in the United States is undertaken by doctors regarded as "nonqualified surgeons" by the American College of Surgeons.[5] In short, even in this most basic area—the specification of qualifications to undertake work graded in its complexity and difficulty—doctors who have met minimal qualifications for licensure are left for the most part to make their own individual decisions as to their competence and capacity to function in various medical spheres.

Understanding doctors' views of medical care requires awareness of the perspectives from which they perceive the medical scene—orientations which conceptualize the problems of medical practice from a personal rather than an organizational perspective. Unlike the organizational theorist, the doctor asks how medicine should be organized so that he can provide his patients with a high standard of care and also maximize his personal and professional satisfactions. The solutions thus obtained might look very different from those posed by medical care experts, who phrase the question in terms of how medical practice might be most effectively and efficiently organized so as to provide a high level of care through maximal use of

[1] *See* R. SHRYOCK, MEDICINE AND SOCIETY IN AMERICA: 1660-1860 (1960).
[2] *See* B. ABEL-SMITH, THE HOSPITALS, 1800-1948 (1964).
[3] *See* B. STERN, AMERICAN MEDICAL PRACTICE (1945).
[4] *See* R. SHRYOCK, MEDICINE IN AMERICA: HISTORICAL ESSAYS (1966).
[5] Roemer, *On Paying the Doctor and the Implications of Different Methods*, 3 J. HEALTH & HUMAN BEHAVIOR 4, 7 (1962).

health resources and personnel. Indeed, the optimal organization of medical resources may require a degree of control and surveillance over the doctor's work which is threatening and unattractive to him. One needs no theory of professional conspiracy to explain conflicts between the health professions and other groups; conflict is a natural product of the different perspectives from which they view the medical context.

## II

## THE ELEMENTS OF MEDICAL CARE

The concept of medical care applies not only to the care received by individual patients but also to the manner in which medical resources are provided and distributed to the population at large. Even if every patient treated received optimal patient care, the medical care system itself would be inadequate if a close congruency did not exist between need and the distribution of services. Thus, systems of medical care must be measured not only in terms of individual care but also in terms of the adequacy of personnel and facilities and the distribution of services among various economic strata and geographic areas. Persons of sufficient ability and motivation must be recruited into the health professions and trained, and the conditions for continuing innovation and adaptation to change must be maintained.

Given the growing demand for medical services[6]—inflated by an increasing rate of utilization for the average person, a growing population, a larger number of persons in age groups that require more concentrated medical attention, and greater health coverage stimulated by new government programs—the number of physicians available to the population in coming years will be inadequate.[7] At the end of 1964 there were 297,200 physicians and osteopaths (active and inactive) who were listed as part of the American health manpower pool. Although the number of doctors relative to the population has been maintained, a much larger part of the total medical work force is involved in nonclinical activities, such as medical research and administration, leaving relatively fewer doctors to meet the growing demands for medical services.[8] In comparing 1950 and 1964, there were more general practitioners in the early period than general practitioners, internists, and pediatricians combined in 1964.[9] There are basically two ways to respond to the situation: we can continue to stimulate the development and growth of medical schools to a much greater extent than has yet been attempted; or the resources available can be concentrated into programs and forms of organization designed to increase the doctor's

[6] *See* H. SOMERS & A. SOMERS, DOCTORS, PATIENTS, AND HEALTH INSURANCE (1962).

[7] *See* U.S. SURGEON GENERAL'S CONSULTANT GROUP ON MEDICAL EDUCATION, PHYSICIANS FOR A GROWING AMERICA (Public Health Service Pub. No. 709, 1959); R. FEIN, THE DOCTOR SHORTAGE: AN ECONOMIC DIAGNOSIS (1967).

[8] N.Y. Times, Sept. 28, 1967, at 53, col. 2.

[9] NAT'L COMM'N ON COMMUNITY HEALTH SERVICES, REPORT OF THE TASK FORCE ON HEALTH MANPOWER 40 (1967).

productivity.[10] Although it is necessary to take steps in both directions, it is not clear that these remedies will have much impact on the vast maldistribution of medical manpower and facilities throughout the United States.[11] Thus far, we have not been extremely bold in considering the development of incentives and subsidies that might stimulate a more adequate distribution of medical manpower.

There are few areas in medical care that can compete successfully with the manpower problem in evoking platitudinous comment. The manner in which we attempt to meet medical demands and the types of responses we evoke in meeting manpower problems will have a vast influence not only on the amount of medical care available but also in its patterning and structure. If we, indeed, decide that major emphasis should be given to increasing the doctor's productivity, then we must be cognizant of the fact that this is likely to change the nature of the physician's role itself with possible dangers of destroying the sustenance aspect of medical practice. The failure to tangle with the real analytical issues in the structuring of medical care is exemplified by the report to the President from the National Commission on Community Health Services.[12] Compare, for example, the two following notions suggested by the Commission:

> It is critically important to make full use of available medical manpower. The physician is neither nurse, social worker, nor physical therapist. He is a physician. His training and talents as a physician must not be dissipated by employing them—except in crisis situations—in any tangential, nonmedical discipline. There are not enough of him in the United States today to warrant wasting a minute of his education and experience on jobs others can do as well. Because it is necessary to face up to this fact squarely, and make the most efficient use of limited physician manpower, health care functions not requiring medical training should be delegated by the physician to other members of the health care team to the maximum extent practical.[13]

> The physician should be aware of the many and varied social, emotional, and environmental factors that influence the health of his patient and his patient's family. He will either render, or direct the patient to, whatever services best suit his needs. His concern will be for the patient as a whole and his relationship with the patient must be a continuing one. In order to carry out his coordinating role, it is essential that all pertinent health information be channeled through him regardless of what institution, agency, or individual renders the service. He will have knowledge of the access to all health resources of the community—social, preventive, diagnostic, therapeutic, and rehabilitative—and will mobilize them for the patient.[14]

[10] In defense of the latter argument, see Ginzberg, *Physician Shortage Reconsidered*, 275 NEW ENG. J. MED. 85 (1966).

[11] *See* NAT'L COMM'N ON COMMUNITY HEALTH SERVICES, *supra* note 9; Darley & Somers, *Medicine, Money and Manpower—The Challenge to Professional Education*, 276 NEW ENG. J. MED. 1414 (1967); N.Y. Times, Sept. 28, 1967, at 53, col. 2.

[12] NAT'L COMM'N ON COMMUNITY HEALTH SERVICES, HEALTH IS A COMMUNITY AFFAIR (1966).

[13] *Id.* at 22.

[14] *Id.* at 21. (Original in italics.)

To all but the most rampant optimists the goals defined in the two statements above will appear inconsistent. Continuing relationships with patients and concern for the patient as a whole by necessity require doctors to engage in tangential, nonmedical functions that do not require his technical medical education. Indeed, the kind of medical stance that maximizes technical forms of productivity is incompatible with the definition of the doctor's role as a coordinator of services and an attendant to the social and emotional welfare of patients. Since this issue is central to future decisions concerning the organization of medical practice, I turn now to a more complete discussion of the consequences of varying forms of practice organization.

## III

### MEDICAL PRACTICE AND BUREAUCRACY

As the needs for greater efficiency and productivity in the provision of medical care grow, and as increasing developments in medical technology demand greater organization and coordination, the arguments toward the bureaucratization of medicine are compelling. Many technical-scientific aspects of medicine can be efficiently organized within bureaucratic forms, thus making it possible to reach more people and to facilitate a more adequate pattern of distribution of medical services. Moreover, bureaucratic contexts facilitate the imposition of quality controls (for example, routine auditing of medical care) and enhance the possibilities for continuing education in a situation of rapid social and technological change. The trend toward greater bureaucratization of medical practice is not only a certainty because of the forces within medical practice, but it is also being encouraged through the growing involvement in medical affairs of other organizational forces; government agencies, labor unions, and other major purchasers of medical care are increasingly conscious of the value received for their investments and are concerned that their constituencies enjoy a standard of medical care at least equal to that of the individual consumer who purchases his own services.[15]

The solutions to some problems usually create others, and it is of the greatest importance that thought and energy be devoted to considering bureaucratic mechanisms and alternatives that counteract some of the more noxious side effects of the growing bureaucratization of medical practice. The great variety of life problems brought to doctors indicates that from the patient's perspective the nontechnical aspects of the doctor's role are important. Indeed, it seems apparent that the physician has to a great extent occupied a sustaining role in Western society, handling a wide range of problems outside the sphere of his technical-scientific expertise. The continuing importance of the social aspects of medical practice is attested to by the increase of utilization of medical resources despite the fact that the level of the population's health is probably higher than ever before. Certainly, the growing

[15] See R. MUNTS, BARGAINING FOR HEALTH (1967).

demand for medical services is in part a product of general affluence, increased consumer spending power, and the expanding provision of medical resources resulting from new medical and government developments. But the nature of medical demand and the wide-reaching character of problems brought to the physician suggest that increased utilization may also be a product partially of the changing organization of social life itself.[16]

As opportunities for intimate personal contacts diminish and as the American population becomes increasingly mobile, problems that have been previously handled in familial, social, and religious contexts may be transferred to formal sustaining professionals (doctors, lawyers, social workers, and the like). Although a wide variety of professionals deal with problems which in previous decades were handled by informal sources of help, it is generally believed that physicians appear to have experienced the most substantial part of this additional consumer demand. Because the formal structure and definition of the doctor-patient relationship provide a legitimate way for expressing intimacy and requesting help, it is only natural that various psychosocial problems and other problems in living should be brought to the physician.

There is little reason to believe that doctors presently deal adequately with the sustaining aspects of their role. But the continuing bureaucratization of medicine threatens even further danger in this sphere, as evidenced by the growing clamor over the contraction of general practice despite the fact that the average consumer of medical care receives better technical services than ever before. One possible source of such dissatisfaction is the commonly held feeling that it is necessary to have someone to rely on during times of trouble. And it is expected that such a relationship would allow an opportunity for expressing deeply felt attitudes, doubts, and uncertainties. Thus, if the sustaining professions are to be effective in responding to many patients' needs and expectations, these professions must be organized to insure some opportunity for the expression of intimacy and for the provision of close personal supports. It is essential that the patient feel that the person to whom he allows access to the private regions of his "self" be truly interested in him and his welfare, and not regard him as one more item on an assembly line.[17] Yet at the same time that societies and their various institutions become more bureaucratized, making the sustaining professions more important than ever before, these professions themselves are becoming more formalized. As already noted, there are many excellent reasons for formalizing medical care, but it is not clear to what extent such relationships can be bureaucratized without seriously damaging the potential emotional sustenance functions of the helping professions.

When we think of bureaucratizing medical practice, we usually conceive of medicine in its more narrow perspective—that is, as an applied science rather than as a

[16] *See* M. BALINT, THE DOCTOR, HIS PATIENT, AND THE ILLNESS (1957).
[17] *See* D. MECHANIC, MEDICAL SOCIOLOGY (1968).

sustaining profession. As doctors become more capable technically, they tend to think of medicine in its more restricted medical aspects. And increasingly doctors trained in modern, hospital-based, scientifically oriented medical schools, operating with heavy patient loads and faced with severe time pressures, resist rendering some of the services the "old family practitioner" saw as an integral part of his role. Moreover, in organizing the technical-scientific components of the doctor's role so that the same facilities reach more people, opportunities for the emotional aspects of medical practice diminish. As Freidson[18] has illustrated, bureaucratic roles facilitate high quality care in a technical-scientific sense, but a certain degree of inflexibility in dealing with patient definitions, expectations, and desires also results from such organizational forms.

Just as it is unnecessary that medical care be organized to fit every personal wish of the physician, so is it equally unnecessary to respond to every whim of the patient. Since medical resources are substantially limited, it is likely that the optimal pattern of medical care from a national perspective will require some compromises on all fronts. There is little point in encouraging a continued pattern of solo, entrepreneurial practice, as it will increasingly become as inappropriate to the dimensions of medical demand and technology as the individual tutor is to modern education and scientific development. However, the character of the particular bureaucratic forms we develop deserves very serious study since the future offers abundant opportunity for the exercise of administrative stupidity.

On a simple logical basis it would appear reasonable to attempt to separate the technical-scientific aspects of medical practice from the more amorphous sustaining function. Presumably large group clinics could provide separate professionals to deal with the needs of different kinds of patients, and some experiments along these lines have been attempted. For example, within the Health Insurance Plan of New York a demonstration program was attempted in which families were assigned to health teams including nurses and social workers as well as medical men.[19] Although many more such experiments need to be attempted, it appears that many patients are reluctant to deal with emotional problems outside the medical context, and they are clearly partial to the physician.[20] Thus, regardless of whether physicians agree to allocate certain problems of patients to other professionals, it is not unlikely that patients will continue to bring emotional problems to physicians despite the availability of other channels of help. Given such a tendency, it appears expedient to develop other social services around general medical services.[21]

The coordination of the doctor's work in conjunction with the work of other

[18] Freidson, *Medical Care and the Public: Case Study of a Medical Group*, 346 ANNALS 57 (1963).
[19] *See generally* G. SILVER, FAMILY MEDICAL CARE (1963).
[20] *See* Freidson, *Specialties Without Roots: The Utilization of New Services*, 18 HUMAN ORGANIZATION 112 (1959).
[21] *See* M. JEFFERYS, AN ANATOMY OF SOCIAL WELFARE SERVICES (1965).

professionals and related health workers raises certain difficulties. For example, if we are to take seriously the notion that work that does not require a medical education be delegated to other practitioners, then the reinstitution of midwifery appears reasonable. Experience in other developed countries suggests that well-trained midwives can provide a level of obstetrical care comparable to the care provided by physicians. But since medical care is largely private, patients may very well choose to receive such care from physicians; and individual doctors, making their own choices, would be agreeable to providing this service. There is danger, however, that even a more highly stratified medical care system than presently exists may develop where those with means buy the services they wish, while those who are less well-off receive what is socially defined as inferior care. Indeed, the social definition of midwifery under such circumstances may discourage the recruitment of competent personnel to this work, resulting, in fact, in inferior care. Midwifery is only offered as an example; it is the general issue to which I wish to draw attention. In a medical market which is largely private, persons with adequate income will be able to buy services from the practitioners of their choice, thus leaving the new physician-substitutes to provide similar services to those with lesser purchasing power. Given this threat of a highly stratified medical care system, as well as the unwillingness of the physician to share control over his work with "lesser specialties," it seems more appropriate to think in terms of new supporting specialties that facilitate the doctor's performance and efficiency but which do not operate in competition with him. In areas where there are, in fact, competing specialties (that is, professionals having a clearly defined sphere of activity), we should encourage independent practice which offers the consumer an alternative to the doctor. But even in such areas as social work, psychological counseling, and the like, there are compelling reasons for providing opportunities for help at the settings where the client is most likely to appear.

The future of medicine is faced with a dilemma common in organization life. Bureaucracy allows a more efficient and effective standard of medical practice and facilitates the use of available resources so that more people benefit. But bureaucracies also develop certain rigidities and inflexibilities in dealing with specific unique problems in that there is a tendency toward standardization of modes of professional practice. The dilemma we face is that the bureaucratic form most appropriate for the efficient organization of scientific medical work is not the best form to deal with the emotional sustenance aspects of medicine, nor does it encourage the flexibility and variation which are so useful in dealing with social and emotional problems.

There is a vast range of possible bureaucratic forms, and it is a serious error to assume that the most typical bureaucratic forms characteristic of government agencies are those best suited to medical practice.[22] Nor is it necessarily correct to assume that

[22] *See* Goss, *Patterns of Bureaucracy Among Hospital Staff Physicians*, in THE HOSPITAL IN MODERN SOCIETY 170 (E. Freidson ed. 1963).

bureaucracies need give priority to quantity over quality or to technical aspects of medicine over emotional and social sustenance. It is not difficult, for example, to conceive of a medical bureaucracy that defines its main goals in terms of the social and emotional needs of patients and gears its activities and procedures toward this end. The difficulty in modern medicine, however, is that although medical bureaucracies often give lip service to the social and emotional needs of patients, the bureaucratic organization of medicine continues to reflect the priority—and it may be a correct one—attached to the technical-scientific aspects of the medical role. Although medical bureaucracies can be organized so that they give emphasis to the patient's education, his social and emotional needs, and comprehensive care, few medical bureaucracies are truly committed to these ideas and willing to assume the necessary economic costs.

While bureaucratic forms may vary, thus fulfilling needs differently, bureaucratic organization regardless of its type poses certain problems from a social viewpoint. Bureaucracy encourages specialized activity, routinized procedures and modes of operation, formalized methods of requisition, and standardized modes of training and evaluating personnel, and there is a strong tendency for bureaucracies to limit client control.[23] On the assumption that professionals know best what is good for the client, patients are usually given little power or formal channels through which to express their dissatisfaction or influence the type of care they receive. Unless known channels for patient influence are available and used, doctor-patient relationships can take on a stereotyped form resulting in the medical staff's giving highest priority to organizational needs and values rather than to those of patients. As clinical settings become larger and more impersonal, the patient finds it difficult to contact his doctor without first dealing with a variety of intermediaries who may try to deflect the patient's request. Since the organization is unlikely to make the patient aware of its staff rotation policies, it is not unusual that he does not see the doctor he expected or wanted to see, and, indeed, the patient may have difficulty finding someone who assumes major responsibility for his care. Moreover, as medical bureaucracies not only develop in size but spread out in space, it is not uncommon for the patient to be sent on a wild-goose chase in attempting to complete some facet of his care. All of these problems, of course, are not unique to bureaucracy, but there is a strong tendency for them to be exacerbated in such organizational contexts.

Assuming that bureaucratic organization is essential in medicine—and I for one would take this position—there continue to be alternative choices open to us. Bureaucracies can be structured so that they offer flexibility and choice to patients with different needs and inclinations.[24] They can also be structured so that they

[23] *See* E. FREIDSON, PATIENTS' VIEWS OF MEDICAL PRACTICE (1961).

[24] For a provocative discussion of the issue of choice within welfare bureaucracies, see B. ABEL-SMITH, FREEDOM IN THE WELFARE STATE (Fabian Tract 353, 1964).

provide patients with power in those areas where critical patient scrutiny and evaluation are likely to improve the quality of services while, at the same time, protecting doctors from frivolous and trivial demands that detract from the over-all quality of medical care. It is not too farfetched to suggest that just as students are demanding some role in decisions at universities that concern their welfare, patients, too, ought to demand some voice in the structure, organization, and provision of services which they pay for directly and indirectly. Although such demands can be excessive, medical care—like education—has not been as responsive as it should be to the many legitimate criticisms of its clients.

In organizing new forms of medical practice, caution is required so that as we eliminate economic barriers to medical care, we do not substitute in their place a variety of other social barriers.[25] The success of new forms of organization in medical care will depend in large part on the flexibility, alternatives, and control mechanisms that are devised to mold bureaucratic processes in a direction which enhances choice and meets needs conducive to the health and welfare of patients as individuals.

## IV

### THE PRINCIPLE OF COUNTERVAILING FORCES IN MEDICINE

One of the most important social changes in medical care in recent decades has been the development of collective power among consumers of medical care. As labor unions moved into the medical care field, patients' interests were consolidated into powerful bargaining forces for the kinds of medical programs deemed desirable. These new attempts on the part of the consumer to structure care alternatives were frequently resisted, of course, but, having banded together, patients' interests were now consolidated into an effective bargaining framework. If the medical profession was not prepared to bargain in a reasonable fashion, the unions were in a position to build and develop their own facilities and disregard local practitioners; when these practitioners placed obstacles in the path of such developments, the vast legal resources available to major labor unions allowed them to carry the battle to the courts.[26] It was clear that public policy concerning health care would never again be the unique province of the medical profession.

The substantial and continually growing involvements of the federal and state governments as purchasers of medical care provide very powerful countervailing forces in the medical care field, and new programs such as Medicare, Medicaid, and the medical programs of the Office of Economic Opportunity afford tremendous

[25] *See* Rosenstock, *Health Behavior*, in THE POVERTY-ILLNESS COMPLEX: A SOCIOLOGICAL ANALYSIS (A. Antonovsky *et al.* eds. 1968) (forthcoming); Mechanic, *Response Factors in Illness*, 1 SOCIAL PSYCHIATRY 11 (1966).

[26] *E.g.*, Group Health Cooperative v. King County Medical Soc'y, 39 Wash. 2d 586, 237 P.2d 737 (1951). *See also* American Medical Ass'n v. United States, 317 U.S. 519 (1943). *See generally* R. MUNTS, *supra* note 15.

opportunities to affect organization of medical care, controls over standards of medical practice, and the qualifications of providers of medical services. For example, in its first year of operation it is estimated that the Medicare program covered five million hospital admissions at a cost of almost two and one-half billion dollars.[27] Under the voluntary part of the Medicare program, it is estimated that payments were made for twenty-five million bills covering physician and other services, at a cost of approximately seven hundred million dollars. Between 1966 and 1967, the proportion of personal health care expenditures involving public funds increased by ten percentage points—from twenty-two to thirty-two per cent—largely due to Medicare. In short, the magnitude and scope of such a program cannot help but have a deep impact on medical care, especially if government administrators have some clear notion as to the directions in which medical care should be moving.

In contrast, the community of physicians is very powerful not only by virtue of its tight and effective organization[28] and unity of sentiments but also because of the nature of the medical care market. Since there is a scarcity of physicians relative to medical demand and a growing scope of utilization stimulated by general affluence, doctors are in a position to boycott effectively new programs without excessive economic hardship, and thus they are in a position to bargain for conditions of service which are favorable in terms of their perspective. The federal government, appreciating the power of the medical community and the state of the medical market, has moved carefully and conservatively in attempting to protect the success of its new programs. In its Medicare program, for example, an exceedingly cautious position has been taken on such central concerns to the medical profession as fees. The willingness of the government to accept direct billing to the patient under the Medicare program and its agreement to accept the doctor's "customary charge" without insuring the concept of a "customary service" (which can be defined as the provision of a service comparable to that provided to fee-for-service patients in the same locality) reflect the caution with which the federal government has approached the sensitive area of bargaining with the medical profession. And there is little question but that the Medicare program has added some increment to the average doctor's income.[29] A panel study of a sample of physicians in New York State[30] found that

[27] U.S. Social Security Administration, Dep't of Health, Education, and Welfare, Health Insurance Statistics, Nov. 20, 1967.

[28] *See* Comment, *The American Medical Association: Power, Purpose, and Politics in Organized Medicine*, 63 YALE L.J. 937 (1954).

[29] There has been a continuing debate as to whether the 7.8% increase in physicians' fees in 1966—the largest annual increase since 1927—was in part a response to the acceptance of the "customary fee" criterion within the Medicare program. For a conservative review of the question, see U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, A REPORT TO THE PRESIDENT ON MEDICAL CARE PRICES (1967); for a less conservative view, see Smedley, *Medicare*, THE AM. FEDERATIONIST (AFL-CIO), Sept. 1967, at 9, 14-15.

[30] J. Colombotos, Physicians and Medicare: A Before-After Study of the Effects of Legislation on Attitudes (unpublished paper presented at the annual meeting of the American Sociological Association, San Francisco, Cal., Aug. 31, 1967).

prior to Medicare only thirty-eight per cent of doctors favored the bill. Following the enactment of Medicare seventy per cent reported approval, and six months later the endorsement rate went up to eighty-one per cent. After the passage of the bill and also six months later, ninety-three per cent of the doctors interviewed indicated that they had planned or were planning to treat Medicare patients.

In contrast, the Medicaid program in New York State has had a much more stormy entrance. Six months following its enactment only forty-two per cent of a sample of New York State physicians favored the program, and a substantial number of doctors are alleged to be boycotting the program. Compared to Medicare, title 19 appears to be less popular among doctors, and although there are many explanations for their reactions, it is very likely that an important element involves a dispute over controls. Unlike Medicare, New York State's title 19 program has attempted to impose regulations dealing with the quality and costs of medical care by specifying criteria concerning who can render specialist care and by attempting to provide a fixed fee schedule rather than using the "customary fee" criterion. In this dispute one can see the clash of powerful countervailing forces, and one begins to get some view of what medical care politics will look like in the future.

As government programs in the medical care field expand in their coverage and as inclusion rules become more liberal over time, concern with costs and quality becomes inevitable. Such new programs provide the government with considerable opportunity to upgrade medical education and levels of medical skill at the same time that they encourage efficient practices. Such pressures obviously frighten professionals who are accustomed to unquestioned independence, and they disenfranchise others with lesser qualifications. If, for example, the government requires that providers of particular services be board-eligible or board-certified in the relevant specialties, such requirements arouse the opposition of many doctors who do not meet these qualifications but ordinarily undertake similar work. In the long run specification of such criteria will upgrade medical practice, but in the short range confrontations are inevitable.

One of the major problems in such confrontations is that the rhetoric of dispute is rarely in terms of the issues at hand. Doctors who are fearful of government regulations concerning the quality auditing of medical care find it more expedient to attack the government's alleged intrusion in the doctor-patient relationship rather than to bargain for a fair and reasonable auditing system that protects both sides from abuse. And the false rhetoric does little to refine and resolve such pertinent issues as what constitutes a fair auditing system, how penalties and authority will be administered, how reviews will be undertaken, how auditors will be selected, and the role doctors will have in their selection. Despite the pervasive paranoia among the medical profession concerning government, there are realistic problems resulting from growing government involvement in medicine, and negotiated safeguards for both doctor and patient are required. The obnoxious attachment of a

loyalty provision to the original enactment of title 18 is symptomatic of possible dangers to the patient's privacy[31] and to the worthy ethics of the Hippocratic oath. Although such problems can be exaggerated, it remains important to insure that government's role in medicine is structured so as to protect the integrity of patients and those aspects of independence which are necessary among professionals. Despite one's attitudes toward the degree of benevolence exercised by the medical profession, it is too much to expect doctors to passively await developments while the structure of their work situation is so radically changing. We can, however, attempt to channel the discourse into more pertinent and constructive areas of discussion.

Just as the medical profession chooses its own rhetoric, so do government officials. Although they may promise "equal access to quality care" to all persons covered by their programs, the powers of implementation are frequently insufficient to induce the appropriate organizational changes. Making medical care a right rather than a dole does not necessarily change the organization of clinics and how they operate, the attitudes of physicians toward their clients, and the liberties medical organizations take with patients of differing social status. Indeed, the increased provision of medical services to underprivileged groups faces problems in many respects identical to those involved in welfare administration generally.[32] If the government pays medical bills directly, they have better opportunity to control the quality and costs of care and to influence the structure of medical practice. In contrast, if the patient pays his own fees, he has greater opportunity to escape the stigma of receiving a welfare service and whatever consequences flow from such a definition. But in the latter circumstance the government has no way of using its influence to insure that the patient receives a good value for his money. Moreover, under the direct billing scheme recommended by the American Medical Association, there is no protection to the Medicare patient that the doctor will not charge an exorbitant fee in excess of the reimbursement possible under the government program. Furthermore, requirements to pay bills before reimbursement can produce difficulties for elderly patients on limited incomes.

In my opinion direct billing would be desirable and conducive to good quality care only if local medical societies would protect the patient against exorbitant fees by accepting a standardized fee schedule within the limits of government reimbursement. Under such conditions patients would have greater freedom in seeking sources of medical care without being labeled as welfare recipients and would, at the same time, have assurance that they would not be held for expenditures beyond those allowable by the government. From the government's standpoint, if there

[31] The Justice Department has conceded in response to ACLU's objections that the Medicare loyalty oath is unconstitutional. 46 ACLU ANN. REP. 31-32 (1967).

[32] *See generally* Handler & Rosenheim, *Privacy in Welfare: Public Assistance and Juvenile Justice*, 31 LAW & CONTEMP. PROB. 377 (1966).

is a predetermined agreement on medical fees reimbursement could be expedited, thus protecting the patient from incurring unnecessary loans to pay medical expenses and negating the need for such obnoxious mechanisms as promissory notes used by some physicians. Here, it appears, is an opportunity to substantially improve the patient's position in the medical care structure, if only the medical societies were willing to undertake action consonant with their verbalized philosophy concerning the freedom of patient choice of doctor and if the federal bureaucracy was able to overcome the inefficiencies of its reimbursement mechanisms.

The field of medical care administration in the United States is complicated by the fact that doctors function in a "seller's market." Unlike England and Wales, where government medicine is used by the mass of the population[33] and where nearly all doctors must depend on the Health Service for their livelihood, doctors in the United States, as noted earlier, are sufficiently busy so that if necessary they can work outside of government schemes. This allows the medical profession a powerful bargaining position, one which permits it to resist to a considerable extent government pressures for change. But there is also evidence that the power of the medical profession is becoming more fragmented as the changing technology and structure of medical practice produce within the health professions new pressure groups who come into conflict with the policies of the American Medical Association. Doctors can no longer work effectively without the availability of the hospital, but hospitals are faced with their own problems and increasingly are looking toward the government for financial support and are showing a willingness to accommodate to administrative pressures from the government. Similarly, medical educational institutions and particular medical specialties are to a greater extent identifying with their own particular problems and spheres of concern, and when their interests are at stake they are willing to form coalitions with the government against the American Medical Association. In the past few years we have had the opportunity to see several such instances: the American Hospital Association supporting the government on Medicare; the medical schools supporting regional government-supported clinics for chronic disease; and the American Psychiatric Association supporting government investments in staffing community mental health centers. The changing political and social climate in the country at large and the growing ferment among the young also have not failed to penetrate the medical schools, where there is a growing consciousness of the social responsibilities of the medical profession.

## V

## THE CHANGING CONTEXTS OF MEDICAL PRACTICE

The greatest problem in health care evident in the United States involves the lack of congruency between the need for medical care and its distribution. Those groups in the United States with the most abundant health problems and need for

[33] *See* A. CARTWRIGHT, PATIENTS AND THEIR DOCTORS: A STUDY OF GENERAL PRACTICE (1967).

adequate medical attention use proportionately the smallest share of health services.[34] Whatever the defects of nationalized systems of care—and there are many—they have made impressive progress in closing the gap between the need for services and their availability.[35] In comparison to the United States there are few developed countries in the Western world that have such great discrepancies in access to care and health status between the rich and the poor.[36] Much of the problem in the United States stems from large pockets of "impoverished health" in underprivileged areas which have not been reached effectively by medical programs already available.[37]

At the same time it is apparent that in recent years the government has made major strides in attacking the morbidity problem among the poor. Through the Medicaid program the states were offered an excellent incentive to increase the scope of health coverage among those with limited incomes, and, although the criteria vary among the states which have thus far enacted programs, the potential scope of such programs can be observed in the liberal requirements specified in New York State. But even Medicaid tends to benefit those areas of the country that have comparatively good state services, and such programs do not do enough to overcome health problems in many of the most impoverished areas of the United States.[38]

Despite short-run setbacks, it appears evident that when the war in Vietnam ends and abundant funds are once again available for a variety of domestic programs, medical benefits through government support will be increasingly liberalized. Since government's role in providing and organizing health care is really only beginning, it is important that we consider various alternatives for structuring care and attempt to learn what we can from other countries concerning the consequences of different forms of organization. I therefore wish to use the remaining space to consider the relevance of the British experience for developing trends in the United States.

---

[34] D. MECHANIC, *supra* note 17, at 236-70; *see* H. SOMERS & A. SOMERS, *supra* note 6; NAT'L CENTER FOR HEALTH STATISTICS, MEDICAL CARE, HEALTH STATUS, AND FAMILY INCOME (Public Health Service Pub. No. 1000-Ser. 10-No. 9, 1964); Sheps & Drosness, *Prepayment for Medical Care* (pts. 1-3), 264 NEW ENG. J. MED. 390, 444, 494 (1961).

[35] For example, recent studies in Britain show no clear relationship between social status and medical care utilization. The studies available suggest somewhat more utilization among the working class who probably need medical services more. *See, e.g.*, A. CARTWRIGHT, *supra* note 33.

[36] Although health and longevity are related to various aspects of culture and society more than to the availability of medical care, it is important to note that despite the affluence of the American health sector, American adult mortality and infant mortality far exceed many other developed Western nations. *See, e.g.*, NAT'L CENTER FOR HEALTH STATISTICS, INTERNATIONAL COMPARISON OF PERINATAL AND INFANT MORTALITY (Public Health Service Pub. No. 1000-Ser. 3-No. 6, 1967).

[37] The high infant mortality rate in the United States is largely a product of the great excess of deaths among nonwhite infants. *See, e.g.*, NAT'L CENTER FOR HEALTH STATISTICS, INFANT AND PERINATAL MORTALITY IN THE UNITED STATES (Public Health Service Pub. No. 1000-Ser. 3-No. 4, 1965). Also, the excess in nonwhite deaths at all ages, except among the very old where data are particularly unreliable, reflect such discrepancies in access to medical care. *See* D. MECHANIC, *supra* note 17, at 236-70.

[38] The most "liberal" Medicaid programs are available in the following states: California, Connecticut, Massachusetts, Maryland, Minnesota, New Hampshire, New York, Rhode Island, and Wisconsin.

## VI

### SOME COMPARISONS BETWEEN BRITISH AND AMERICAN MEDICINE

The major goals of any medical system are to provide and distribute health services to those who need them and to use the resources, knowledge, and technology available to prevent and alleviate disease, disability, and suffering to the extent possible under prevailing conditions. There are many alternative ways in which these goals may be pursued, and the form that health institutions take is inevitably related to the form of other societal institutions and to the economic, organizational, and value context of which they are a part.

Most medical structures, as in the case of other social institutions, have not been organized to fit a plan of maximal efficiency. Instead, they are "hammered out" in the politics of compromise, responding as well to tradition, societal need, and changing technology. The organization of the English National Health Service illustrates this point since it was clearly part of a long evolution of social services, and it expressed values and embodied traditions that were in no sense new.[39] By the second half of the nineteenth century the poor in England had gained the right to institutionalized care when they were sick. In the Metropolitan Poor Act of 1867[40] it was explicitly acknowledged that it was the obligation of the state to provide hospitals for the poor. The National Health Insurance Act of 1911[41] provided wage earners with a general practitioner service not so different from the one available today. Thus, the formation of the National Health Service in 1948[42] served to extend guarantees of access to care and to organize the nation's hospitals into a national scheme, but the Service itself was of an old and traditional cloth, embodying many of the irrationalities and organizational absurdities that existed prior to the National Health Service. We, too, are in this position as we forge ahead in developing new programs. For as we compromise with the medical profession and other groups to facilitate the implementation of particular organizational forms, we allow various absurdities to persist which will plague us in the future. I believe that the billing arrangements under the Medicare Act constitute one such example.

Essentially, the English National Health Service was organized in three parts. Hospitals were organized on a regional basis to assure greater rationality, thus improving to some extent the very poor distribution of beds and facilities. General practice was, for the most part, organized separately from the hospital system, very much extending the form of the medical panel as it existed under the National Health Insurance Act of 1911. The general practitioners, slow to accept the inevitability of the new National Health Service and weak in their prestige and bargaining

[39] *See* B. ABEL-SMITH, *supra* note 2; H. ECKSTEIN, THE ENGLISH HEALTH SERVICE (1964); R. STEVENS, MEDICAL PRACTICE IN MODERN ENGLAND (1966).

[40] 30 & 31 Vict., c. 6.

[41] 1 & 2 Geo. 5, c. 55.

[42] 9 & 10 Geo. 6, c. 81.

position, found themselves with little power but to grumble as the government pushed through a "deal" with the more prestigeful hospital doctors—a deal that won their support and cooperation.[43] Previous to 1948 many general practitioners took on work in hospitals that could not support a full-time hospital doctor, but the new organization of hospital regions allowed assignment of consultants to these institutions, thus more completely disenfranchising the general practitioner from hospital work. Moreover, the salaried hospital doctors were no longer in any sense beholden to the general practitioner for private referrals, and this perhaps has led to an attitude that more readily allows expression of the status distinction between the general practitioner and the hospital consultant—a distinction that has become in recent years more pronounced than ever before with the growing technological sophistication of specialized medical work. Although it was anticipated that the conditions of general practice would be improved through the establishment of general practice centers supplied with ample diagnostic facilities and ancillary help, neither the practitioners themselves nor successive governments were particularly enthusiastic about the idea. The doctors coveted their independence, distrusted both the central and local governments, and were wary about working under the gaze of their medical colleagues. The government, preoccupied with other problems of some magnitude, was probably reluctant to expend the substantial sums necessary to improve the conditions of general practice.

Although conditions in Great Britain and the United States are not comparable, I believe that American doctors have an important lesson to learn from the British experience. British general practitioners have done so poorly in part because they have taken a negativistic and unconstructive stance in opposing inevitable social changes. Had they taken a more constructive view toward social conditions, they might have done much not only to enhance medical practice but to elevate their own position within the structure of the National Health Service. Organized medicine in the United States has also been characterized by stubborn and unconstructive responses to government attempts to attack pressing social problems in the medical field. Although the American Medical Association is no doubt successful in delaying and deflecting programs of change in the short run, they may have a lesser role in structuring future solutions. For example, instead of fighting government subsidy of medical students, thus having a detrimental impact on the quality and range of manpower attracted to the medical profession, the American Medical Association could play an impressive role in insuring that government fellowships would not infringe on the choices made by the student and the integrity of medical practice. Indeed, as the image of the American Medical Association becomes more tainted, its ability to provide leadership among informed and respected medical men

[43] *See generally* H. ECKSTEIN, PRESSURE GROUP POLITICS: THE CASE OF THE BRITISH MEDICAL ASSOCIATION (1960), for a brilliant analysis of the bargaining relationships between the British Medical Association and the Ministry of Health.

is undermined. I have little doubt that leading medical figures will to a larger extent participate in ad hoc policy-making groups outside the committee sphere of organized medicine itself.

In one major sense, the situation of general practice in England and Wales portrays in vivid form a dilemma increasingly characteristic of the United States and other Western countries—that is, the dilemma concerning the organization of general practice services within the over-all structure of medical practice. As medical practice becomes more specialized and more dependent on laboratory aids and technical diagnostic approaches, there has been growing concern in defining the relevance and appropriateness of the general practitioner in the over-all scheme of services. In the United States the noticeable departure of doctors from the general practice role poses the important issue of whether or not vast effort should be devoted to reviving or restructuring such services. In England it is believed that the general practitioner has a unique role in dealing with the social and psychological problems of patients as well as serving as a "first line of defence in times of illness, disability, and distress."[44] However, such definitions of the role are rarely accompanied by an explanation of how such a stance might be effectively communicated to the doctor except in the grossest generalities. Since medical education in Britain is extremely conservative and based predominantly on hospital practice, the average doctor does not always assimilate such socially benevolent views.[45] He, too, frequently identifies with the values of the medical school, which places greatest emphasis on the diagnosis and treatment of less common disorders and not on those most frequently seen in general practice. Even more important, however, is the fact that the stance the doctor takes toward his patients is determined as much by the conditions under which he practices as it is by his own motives and values. To the extent that the doctor is faced by a large panel of patients and an exceedingly heavy work load, it becomes difficult for him to practice in a manner which gives high priority to psychological and social needs of the patient.[46] The average general practitioner is far too busy to provide a high standard of social medicine and emotional sustenance.

We are now in a situation in the United States where we are being urged to restimulate general practice and to institute comprehensive medicine at the same time that we are encouraged to meet growing medical demands by increasing the doctor's productivity. But the social changes required to increase the doctor's productivity are contrary to the gains we anticipate would result from a revitalized general practice. To the extent that the doctor's time is organized to provide a maximum of technical services in a particular period of time, it becomes difficult indeed to enhance those aspects of the doctor's role that nourish emotional and social health.

[44] BRITISH MINISTRY OF HEALTH, THE FIELD OF WORK OF THE FAMILY DOCTOR (GILLIE REPORT) 9 (1963).

[45] *See* T. McKEOWN, MEDICINE IN MODERN SOCIETY (1965).

[46] *See* Mechanic, *Doctors in Revolt: The Crisis in the British National Health Service*, in ENGLISH SOCIETY (I. Weinberg ed. 1968) (forthcoming).

In fact, there is no excuse for failing to do everything possible to increase substantially the production of physicians. Vast subsidies should be provided for medical schools that expand their production of doctors, and the government ought completely to subsidize the direct and indirect costs of medical education for students who are willing to agree to practice for some period after their training in areas officially designated as "medically needy." Such a program would not only help alleviate the difficult financial state of medical schools but would also draw doctors from a wider range of talent irrespective of economic background. It would also provide some incentive for helping to redistribute in a more equitable way the nation's medical manpower.

The question of general practice also brings out in sharp focus some of the economic issues underlying health care, although they take a somewhat different form in the United States and Great Britain. Although the impression is often given in both countries that patients receive the best medical care that money can buy, the kind and quality of medical care depend very largely on the funds invested in health care and health resources. In spite of the fact that the National Health Service tries to make access to medical care more equitable, its presence does not insure the availability of a high standard of care to the average patient. The typical doctor sees far too many patients to assess their problems carefully, and he devotes far too little time to each patient. In a study of a random sample of general practitioners in England and Wales,[47] more than half of the doctors studied reported that under present conditions of organization it was not reasonable to expect general practitioners to provide a high standard of medical care or to practice good social or preventive care. More than two-fifths of the doctors felt it was not even realistic to expect the general practitioner to adequately screen out patients with serious physical disorders, to keep informed of new knowledge in medicine, or to provide a high quality doctor-patient relationship. Although we do not have comparable data relevant to medical practice in North America, there are indications that the situation is not much better.[48] To the extent that medical practice affects mortality and morbidity—and this may be a dubious assumption—there is little basis for assuming American superiority.[49]

Economic issues affect medicine in other ways as well. Because such high eco-

[47] D. Mechanic, General Practice in England and Wales: A Report on a Survey of a National Sample of General Practitioners (mimeo., Department of Sociology, University of Wisconsin, 1968). *See generally* Mechanic, *General Practice in England and Wales*, 6 MED. CARE (1968) (forthcoming).

[48] *See* K. CLUTE, THE GENERAL PRACTITIONER, STUDY OF MEDICAL EDUCATION AND PRACTICE IN ONTARIO AND NOVA SCOTIA (1963); Peterson *et al.*, *An Analytic Study of North Carolina General Practice 1953-1954*, J. MEDICAL ED., Dec. 1956, pt. 2, at 1. *See generally* COLUMBIA UNIVERSITY SCHOOL OF PUBLIC HEALTH AND ADMINISTRATIVE MEDICINE, THE QUANTITY, QUALITY, AND COSTS OF MEDICAL AND HOSPITAL CARE SECURED BY A SAMPLE OF TEAMSTER FAMILIES IN THE NEW YORK AREA (1960), for a picture of the quality of work of general practitioners in hospitals.

[49] *See* Peterson *et al.*, *What is Value for Money in Medical Care?*, [1967] 1 THE LANCET 771; Moriyama & Guralnick, *Occupational and Social Class Differences in Mortality*, in MILBANK MEMORIAL FUND, TRENDS AND DIFFERENTIALS IN MORTALITY 61 (1956); references cited notes 36 & 37 *supra*.

nomic valuation is placed on the doctor's technical services, certain aspects of medicine which may still be desirable become relatively uneconomical. Doctors are increasingly unwilling to make house calls because of the loss of time and money intrinsic to such inefficient forms of practice; patients as well would be unwilling to pay the cost of such house calls as measured against a comparable value received in office practice for a given time unit. The unwillingness to make house calls is highly developed in the United States where doctors, for the most part, work on a fee-for-service basis; but the proportion of the doctor's time spent in home care is decreasing in developed medical systems throughout the world.

Finally, it is important to consider the relevance of general practice to modern technical medical care. The general practitioner is a doctor of first contact. Ideally, he is sufficiently trained, technically speaking, to deal with most of the common disease conditions and to recognize those less common situations which require specialized attention. Moreover, he is a kind of medical ombudsman in that he is expected to make assessments of the quality of specialized services available, to channel his patients into those routes most likely to offer a high quality of care, and to survey and, if necessary, intervene in the medical care provided to his patients so that their interests are best served. He is an educator in that his role is partially concerned with instructing the patient in health care, advising him on general medical problems, and encouraging his understanding and cooperation in treatment. Also it is assumed that he is sufficiently conversant with the personal and social history of the patient so that he can provide a meaningful kind of emotional sustenance and can consider social and personal factors in managing the patient and his illness in an optimal manner. Finally, it is assumed that taking into account the social and psychological dimensions of medical care enhances treatment decisions in that social facts and attitudes affect the course of illness and the range of disability.

It is reasonable to inquire as to what structural and organizational factors would allow such a role to be implemented and what social features would interfere with its success. Obviously the doctor must be reasonably competent in a technical sense, and conditions must be conducive to allowing him to maintain and upgrade his skills. Also he must be in a position to assess realistically the qualifications of specialists in the community and the quality of care they are able to provide. Moreover, he must have real alternative choices among such specialists, and this assumes access to a large specialist pool. Furthermore, he must be in a position to provide continuing care to his patients and be sufficiently aware of their histories and needs to instruct and advise them intelligently. It is also assumed that his relationship with the patient is a continuing one and that his practice is characterized by a relatively low degree of mobility. Finally, it is assumed that he is sufficiently in contact with other doctors providing care to his patients so that he can bring important facts concerning their health and personal histories to these doctors' attention and, in general, can look out for his patients' interests when they are placed within par-

ticular referral routes. Using these structural prerequisites, it is instructive to evaluate the role of general practitioners as they most commonly function in Britain and the United States.

England is an interesting country to assess since practitioners and officials frequently express pride in their ability to resist the trend toward specialization and impersonal medicine. The average general practitioner there is as well trained as his American counterpart, although the scope of his responsibility for caring for patients is much more limited because of his exclusion from hospital practice. He practices, for the most part, in isolation from other doctors who can scrutinize his practice and can help correct his mistakes, and he usually does not experience situations where medical problems are intensively discussed and skills sharpened. Moreover, his busy practice, largely devoted to common and uncomplicated medical problems, provides little incentive to maintain and develop new skills in dealing with less common disease entities. Although efforts are made to encourage continued postgraduate involvement, the doctor's investment in continuing education is less than ideal. Although the general practitioner may know specialists by reputation, because he has little place in the hospital he rarely has a personal opportunity to scrutinize the quality of the consultants' work, and even if he did he would have little power to affect the hospital situation. Finally, unless he is located in a major medical center such as London, he may have few real alternatives for referral, and his major role may involve scheduling an appointment for the patient or arranging for a hospital bed. Frequently patients are referred to the hospital without designating a consultant at all.

The continuity of general care in Britain is very much disrupted because the doctor has no place or responsibility in his patient's care once the patient is sent to the hospital. Sometimes the hospital report on the patient is so late that the doctor is not in a position to follow up treatment when the patient returns to him. Moreover, the separation of the general practitioner from hospital care usually means that his knowledge of the patient will not be used at a time when it might be most relevant. Furthermore, the general practitioner has no controls or sanctions to exercise in relation to the hospital or the consultant if he feels his patient is not receiving optimal care. Even if his contribution were valued by the hospital, his own feeling of lack of welcome and his lower prestige relative to the consultant make him reticent to interfere in hospital work. In short, despite the high ideals with which general practice is often described within the National Health Service, the location of general practice within the structure of care does much to negate the possibilities of the general practitioner's role.

General practice in Britain, however, has some assets more obviously lacking in general practice in the United States. British populations are less geographically mobile, and individual practices are more likely to be organized so that they correspond with neighborhood and family patterns. Moreover, the typical British general

practitioner seems to know his community and patients better than does his American counterpart, and he spends much more time visiting their homes. He appears to have a better appreciation of the social problems existing in the community and how these problems impinge on the life and health difficulties of his patient. Indeed, the British general practitioner seems more concerned with the social aspects of medicine, although the organization of general practice does much to interfere with the success of a social viewpoint.

The role of the American general practitioner is more difficult to describe since it is less patterned and more variable. The American situation provides opportunities for both better and poorer general care than is available in Great Britain in that it provides the general practitioner a greater chance to use his influence to encourage and stimulate a high level of medical care, but it also provides greater incentive to exploit the patient for economic gain and greater need to protect himself from competition with other community practitioners.

Although the typical American practitioner is no better trained than his English counterpart, he undertakes a wider variety of work because of his access to the hospital. Although this increases the risk of errors in the management of a serious disease, it also provides incentives for the doctor to maintain his skills, and it encourages greater contact with other doctors. Moreover, in such situations the doctor's work is more visible to his colleagues since much of his activity takes place in the more open atmosphere of the hospital where others obtain some opportunity to observe how he manages his cases. However, because of the economic structure of general practice in America, there is greater incentive for a doctor to keep his patients and treat them himself than to refer them to outside practitioners. The American doctor is frequently faced with the threat of losing his referred patients not only because of the competitiveness of private practice, but also because of patients' increasing sophistication concerning the qualifications of doctors. If the doctor is in group practice, he can protect himself by restricting referrals within the group, but this severely restricts the range of care he can provide his patients. In other situations he may seek to avoid loss of his patients by referring patients to specialists outside his immediate locality. The convenience factor is thus likely to bring the patient back to his original doctor. In short, it is reasonable to believe that doctors will develop solutions to protect themselves and their practices which may not be conducive to the highest level of care. Therefore it is necessary to encourage organizational forms which are conducive to practicing a high level of care in the patients' best interests.

In contrast to his English counterpart, the American general practitioner has a better opportunity to assess the competence of his colleagues since he may come into closer contact with them through hospital work and consultations. But the extent of his awareness can be very much exaggerated, and it is often based on hearsay rather than on a serious opportunity to evaluate colleagues' work. Since the Ameri-

can specialist, however, is dependent on general practitioner referrals to a large extent, he is more susceptible to the general practitioner's influence. Thus, in this respect, the American general practitioner is in a much stronger position to play the role of a medical ombudsman and to influence the specialist in directions conducive to his patients' well-being.

The same conditions and scope of flexibility that provide the American general practitioner with an opportunity to promote the interests of the patient also promote a variety of abuses. The incentive to maximize income and, therefore, to retain one's patients encourages the doctor—perhaps not consciously—to undertake work beyond his capacity, and it may bring about unnecessary and harmful medical procedures.[50] Moreover, the referral system itself encourages trading relationships, some regarded as clearly unethical such as fee splitting, others more ambiguous from an ethical point of view but probably not conducive to a high level of medical care. With the studies available, it is impossible to ascertain to what extent the greater flexibility of referral in the United States serves to maximize patients' care as opposed to benefiting the doctor; the optimal interests of the patient and his doctor are not always compatible, however.

In contrast to the British general practitioner, the American doctor is less likely to have his patient population concentrated in one small area, and his patients are more likely to be geographically mobile. Thus the costs of home care are greater, and it is more difficult for the doctor to know his patient and his family situation well. Also, like the British general practitioner, his work load under present conditions of demand is sufficiently large to make it difficult to provide the time and attention necessary to deal with emotional and psychosocial problems of patients.

## VII

### SOME FINAL NOTES ON MEDICAL PRACTICE IN THE FUTURE

Although it is possible to construct ideal models of what medical care should be, the types of medical care programs that will evolve in the future will be of the same cloth that presently exists. Despite the rhetoric and enunciation of high ideals, we should be aware that medicine will accommodate to the community forces that affect it, and the community will have little impact on the over-all structure of medical services unless it can modify the community conditions, resources, and demands that compel medical adaptations. Ultimately, the condition of medical practice will depend on who controls the organization and structure of medical work, and this is the basic key to the growing confrontations between government and the medical profession.

The deficiencies obvious in medical practice in the United States and Great Britain have led many informed observers in both countries to suggest solutions that are

[50] *See* Roemer, *supra* note 5; COLUMBIA UNIVERSITY SCHOOL OF PUBLIC HEALTH AND ADMINISTRATIVE MEDICINE, *supra* note 48.

strikingly similar; indeed, these suggestions seem to take what appears to work best in both systems and combine their advantages. The concept of health centers—bringing together large numbers of doctors in association with supporting specialties and ancillary workers to provide medical care for defined geographic groups—offers opportunities to improve not only the technical quality of medical care, coordination of services, and the level of emotional and social care, but also tremendous incentives for medical education, supervision and control over quality of services, and more economical use of medical resources. Although the National Health Service in Britain was designed on the assumption that such health centers would become widespread, it is only recently that the government is making a serious effort to encourage such organization.

In a recent article in the *New England Journal of Medicine*,[51] Russel Lee endorses the practicality of community health center organization in the United States. These health centers, as he visualizes them, are to be staffed by group-practice clinics and supported by prepayment plans in which consumers have a voice. He sees the health center integrated with the hospital, extended-care facilities, convalescent homes and nursing homes, and facilities for the long-term care of the mentally ill. He believes that such health centers should be organized around populations of approximately 150,000 people and units of approximately 750 beds. He further notes:[52]

> The people should "belong" to the center as they belong to a church. They should be organized as a consumer co-operative group, should bargain with the group practice clinic to obtain their care on a capitation prepaid basis and should support the operation of the center by a fixed monthly fee.

Such solutions to the problems of medical care are more easily voiced than accomplished. But with medical care in a state of crisis and medical thinking in a state of ferment, and with vast federal and state funds flowing into the medical care area, there is a great opportunity for constructive government action that provides the incentives for the restructuring of medical care so that the distribution of services are more equitable, the delivery of services is more effective, and the organization of medical care is geared more closely to the medical and social needs of the population. We must constantly be aware that the various facets of the medical care area—the financing of medicine, medical education, building of hospitals, development of new specialties, and so forth—are intertwined in a complicated net, and that decisions made in any sphere have consequences throughout the entire medical structure. We must attempt to use the growing government influence in medical care not only to increase the scope and quality of medical care, but also to insure that new medical structures provide a range of choice and a scope of action that facilitate serving man not only as a biological entity but also as a person.

[51] Lee, *Provision of Health Services*, 277 NEW ENG. J. MED. 682 (1967).
[52] *Id.* at 685.