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ADDRESS OF THE RETIRING PRESIDENT

An Evaluation of Full-Time and Group-Practice for the Clinical Faculty of a Medical School*

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In an effort to bring to you a message worthy of this office and fitting for the changing times in medicine, I shall attempt an evaluation of full-time appointments and group-practice for the clinical faculty of a medical school.

Full-time group-practice has been in operation in private clinics in this country for more than half a century and has achieved outstanding success in a number of institutions, the oldest and largest of which is the Mayo Clinic. Modern business methods of organization and operation have been applied in the care of the sick on both large and small scales with a degree of satisfaction to both patients and medical staffs that leaves no doubt about the great efficiency of the system. All fees for professional services are paid to the clinics, and all expenditures, including remuneration and travel expenses of the professional staff, are paid by the clinics. Some of the large private clinics have at the same time made valuable contributions in the fields of medical research and postgraduate teaching and graduate training of specialists in the various fields of medicine. It is appropriate to emphasize here that these achievements have usually been realized by the utilization of the earnings of the clinics from professional services and not from gifts or grants from outside sources.

Full-time employment of members of the preclinical departments of medical schools was a development of the Nineteenth Century and came into widespread use first in the German universities. It has met with such great success in both teaching and research that at present nearly all preclinical medical education throughout the world is conducted on that basis.

In the early stages of the reformation in medical education in the United States that began about forty years ago, certain universities started full-time appointments for a limited number of the members of the clinical departments in an endeavor to bring their work more nearly in line with that of the full-time members of other university departments. There were two forms of appointments, namely, geographic full-time and strict full-time, and the educational and resident training activities of each form were centered about a teaching service of patients who paid no fees for professional service. Geographic full-time was introduced first by Harvard University and the Peter Bent Brigham Hospital in 1913. The professor heading a department and some of his associates were provided with offices in the hospital and spent their time there and in the medical school engaged in academic work for which salaries were paid. They were also privileged to do private practice in the institution and collect their own fees. The plan has since been extended to other clinical units of the Harvard Medical School, and the only limit placed on private practice is the broad statement that "private work is not to interfere with University duties." There is no provision for any portion of the private earnings of a full-time appointee to go to the University or the hospital. This system, in either the original form or variously modified, has been adopted by other universities and today is perhaps the most widely used full-time plan. But under some of the modifications, it is possible for the appointee to spend so much time at private practice in the institution for his own financial profit instead of at teaching and clinical investigation that the academic motive of the plan is greatly weakened. In certain universities there is a limit placed on the amount of income from private practice which may be retained by the clinical appointee, the balance, if any, going to the medical school to be used for a variety of purposes.

Strict full-time was introduced first in 1913 at Johns Hopkins University and shortly afterward at Washington University and Barnes Hospital, assisted in both universities by grants from the General Education Board. Under that plan, the professor heading a clinical department and a few of his associates not only confined their work to the premises of the medical school and hospital but received university salaries as the sole source of remuneration aside from that derived from writing, outside lecturing, and awards which seldom have been substantial. Private practice was not absolutely obligatory, but if for reasons of research or otherwise a full-time staff member elected to care for private patients, as he sometimes did, the professional fees were collected and

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turned over to the university for use in a variety of ways depending on the institution.

The object of strict full-time was to relieve the appointee of the necessity of earning money by treating private patients who were not used for teaching and were estimated as being too often of little scientific interest. He would be free to teach, direct the work of assistants, and participate in the care of the service patients, with emphasis on those of educational and research value. He would also be able to engage more extensively in laboratory and clinical investigation than under any other system. In the course of twenty years following its introduction, strict full-time was put into effect for a limited group of the clinical faculty of eight universities—one state and seven private. For that purpose, six of the universities received grants-in-aid from the General Education Board. One of the eight subsequently changed to geographic full-time, and two changed to part-time. During this period, the General Education Board also made grants-in-aid to two universities, one private and the other state, for the establishment of geographic full-time, and each has since retained that status.

In the past fifteen years, very few universities have adopted the strict full-time plan with the appointees freed from the necessity of earning money from private practice. This is apparently related to increasing costs and the fact that the General Education Board has not contributed to the establishment of full-time units during the period. But in recent years, some of the universities that are operating most successfully on that plan have expanded it, partly by making greater use of income from professional services for support.

In nearly all universities employing either form of full-time for a part of the clinical faculty, there exists a much larger part-time clinical faculty whose appointments vary widely according to special fields of work, amount of time devoted, scale of remuneration if any, and extramural activities. Also there are large numbers of full-time fellows and members of the house staff; and when they are included, the full-time personnel approaches or exceeds that of the part-time staff.

Despite the great success realized from group-practice in private clinics, it has been little used in the clinical departments of medical schools. At Duke University, some of the members of the clinical faculty receive smaller salaries than others who are on a strict full-time basis, but they carry on group-practice on private patients in Duke Hospital and the Private Diagnostic Clinic. The latter is managed by a business organization independent of the university. The income goes partly for operating expenses, partly for a building fund in lieu of rent to the university, and partly for research in the participating department. The remainder is divided among the department members according to the amount of work done by each individual. A somewhat similar procedure is in operation for the surgical staff of the Hospital of the University of Pennsylvania.

At The University of Chicago, the members of the clinical faculty are appointed on a full-time group-practice basis and render services to both paying and non-paying patients in both hospital and out-patient department. All fees for professional services are set and collected by the university and go into a common fund to be used for the best interests of the clinical departments. The salaries of the clinical faculty are paid by the university and are based collectively but not individually on three types of service, namely: academic duties, professional services to patients who do not pay professional fees, and professional services to patients who do pay professional fees. All patients in both hospital and out-patient department, except a small percentage of the private class, are used in the educational program.

After this survey, it is in order to say something of the influence which full-time and group-practice have had on teaching, research, patient care, graduate training of medical specialists and teachers, and on medical economics as it affects both the universities and the full-time members of clinical departments. Obviously this is a difficult task, approached with hesitancy, since there are so many variations of both strict and geographic full-time and the problems are numerous, some being very controversial and still unsolved.

Teaching and research are the two activities in which a university is primarily interested, and but for them it assuredly would never enter the field of clinical medicine. The established facts and disciplines of clinical medicine may be taught equally well by part-time and full-time clinicians provided they are equally qualified, and undergraduate education in clinical medicine is being well done in many schools without full-time members of clinical departments. But undergraduate clinical teaching has been improved by the full-time system because of the greater attention that has been paid to teaching obligations. The best clinical teacher, whether part-time or full-time, is also an investigator, since the student should not only acquire a sound knowledge of practical medicine but also be exposed to the spirit of inquiry and the techniques of advancing medical knowledge. All things considered, the research incentive is more

apt to be imparted by the full-time clinician who is also engaged in investigation.

That full-time has increased the quantity and improved the quality of basic research work of the clinical departments of American universities is a fact so well demonstrated that it scarcely calls for further discussion. Many of the most important contributions to clinical medicine during the past thirty years have been made by full-time clinicians. Good laboratories and budgets for research have practically always been provided as an essential condition for the establishment of such appointments. Full-time, the strict more frequently than the geographic, saves time and frees time that can be devoted to research; and both the contractural obligation as well as the desire to investigate assist the appointee in realizing his goal. Part-time staff members more frequently do good investigation if working in a department containing some full-time members. But there are also failures at research under full-time, the fault most frequently of the man but sometimes of the system. If the head of a department is neither provocative nor productive, most of the members may follow in his wake, and no system will make a successful investigator out of a weak or misfit man. But a potentially productive full-time man may fail as a result of inadequacy of supervision or financial support.

The care of patients may be as well done on one type of appointment as another, depending on the amount of time and attention which is devoted to them. Full-time men giving much time to other duties including research may not and should not necessarily be expected to do all-around routine clinical work as well as able and experienced part-time men who, in their daily professional activities, devote much more time to it. But the full-time men who make the most important basic contributions to knowledge usually restrict their clinical and research work to special fields. This plan makes it possible for them to develop a high standard of specialized professional service to patients and at the same time make use of many of the patients for clinical investigation. With specialization in a sufficient number of fields and a liberal amount of overlap, it is thereby possible for the full-time staff to cover all of the work of a clinical department.

The creation of medical specialists in the various clinical fields by the resident training system is on the average better done when at least a part of the clinical faculty are on a full-time basis. If there is a large ward service of patients receiving free professional care, mainly at the hands of the resident staff, the quality of the service is enhanced by the presence of a full-time chief and associates for consultation, assistance, or actual rendering of professional care, such as the performance of a difficult operation. Research can more readily be made a part of the resident training program if there are full-time members of the attending staff who are actively engaged in research. Also, the surest way of making efficient clinical teachers and investigators out of suitable candidates who have completed the resident training is to have them continue full-time work as junior members of the faculty of their respective departments.

The economic problems of the clinical departments are among the most involved and difficult to solve of all problems that arise in the field of university education. It is the desire of the university, which is concerned primarily with teaching and research, to have a financial policy for the clinical departments as nearly the same as that for all other university departments, consistent with the difference between the duties which the two groups are called on to perform. The duties of the full-time members of the clinical departments consist of teaching, research, and the practice of medicine, while the duties of the full-time members of other university departments consist of teaching and research.

Although the practice of medicine is essential for clinical teaching and certain types of research, it is not primarily an academic discipline but the rendering of a human bodily service, frequently of vital concern to the patient and an important responsibility for the doctor. It is the execution of a legally binding agreement between doctor and patient under which the doctor undertakes the investigation and treatment of the disease of the patient. The patient enters the university hospital or out-patient department primarily not to be utilized for academic purposes but for the purpose of having his health improved or restored. If mistakes are made in medical care, whether rendered gratuitously or for pay, the doctor and not the university is held accountable regardless of the nature of his appointment, and he may be sued for them. And although the financial responsibility for malpractice of the strict full-time clinician may be borne by the university, the stain of professional inefficiency or negligence is not removed from him thereby. It is obvious that in these particulars the care of patients differs extensively from the purely educational disciplines of teaching and research, and consequently its financial implications may differ extensively from those of other university departments. The universities clearly recognize the financial difference and the magni-

tude of responsibility of patient care when, in dealing with paying patients treated by full-time staff members, they usually make charges for professional services commensurate with those made in private practice which are greatly in excess of charges made for instruction. Under this policy the income to the university from the paying-patient part of the practice of a successful full-time clinician who is also a successful teacher and investigator is often very much greater than that from his teaching.

The most desirable plan for the clinical faculty of a university possessing adequate medical school and hospital facilities and desirous of carrying on clinical teaching and research with as nearly as possible the efficiency of the rest of the university, should be some form of full-time appointment and group-practice of medicine on both paying and non-paying patients. The organization of all successful businesses, private medical clinics, and large engineering and law firms calls for full-time employment of the entire personnel on a co-operative or group basis. Why should not the same organization apply to the clinical division of a medical school? It would provide favorable teaching and research facilities for many more members of the clinical departments than exist at the present time. However, such appointments, in some ways, might not be as advantageous as those enjoyed by members, particularly heads of departments, who serve on either a strict or geographic full-time basis.

There are universities in which the existing clinical departments could scarcely be reorganized on this basis for a variety of reasons, such as geographic separation of medical school and hospitals, disproportionate hospital facilities for paying and non-paying patients, an inadequate budget for research, and failure of either the university or the clinical faculty or both to adjust to the financial and educational realities of the situation. However, in some of these institutions it should be possible to realize much of the benefit to be derived from the system, such as utilizing paying patients more fully in the educational program, if the professional services for both paying and non-paying patients were performed by the staff operating on a group-practice basis but organized independently as an association of physicians similar to that of some full-time group-practice private clinics.

There are other universities which possess the physical facilities and financial resources that would make it possible for them to operate the clinical departments on a full-time group-practice basis. But this can only be done if they render professional services in both hospital and out-patient department to both paying and non-paying patients. A great deal of administration by opportunism with unequal and unfair financial remuneration of different members of the same clinical department could thereby be avoided. If only non-paying patients are cared for, it will be financially impossible to operate on this basis since sufficient funds cannot be obtained for the purpose either by private universities from endowment and voluntary contributions or by state universities from tax appropriations. The only feasible way is to derive a large part of the budgets of the clinical departments and of the hospital and out-patient department from fees paid by patients for professional and hospital services. That this can be accomplished has already been demonstrated in The University of Chicago School of Medicine. It has been accomplished mainly because of educational and economic adjustments on the part of both the university and the clinical faculty to the recent economic and social changes that have taken place in the country, and to conditions resulting from changes in the quality of medical care.

Within the past two or three decades, there has been a tremendous advancement in the quality of medical care including that rendered in the teaching hospitals and out-patient departments of medical schools. At the same time, there has been a very appreciable elevation in the economic standards of the masses of the people and also a reduction in the economic standards of the upper levels of society. The quality of professional service in the hospital and out-patient departments at the various levels of accommodations has been high enough, and the number of patients at the different economic levels who are able and willing to pay for such service has been large enough to make it possible for the university to collect money in professional fees mainly from those of moderate and lower income levels to meet the major percentage of the budgetary requirement. An additional economic advantage of utilizing a large percentage of patients of these economic levels is that they pay for hospital service either directly or through various forms of insurance. And with appropriate methods of assignment and control of students and internes, it has been possible to utilize paying patients for routine undergraduate teaching and training, and a part of the training of the resident staff, with just as great a degree of success as that realized with non-paying patients. Junior clerks are assigned to duty in the hospital and senior clerks in the out-patient department. However, it is also essential to have patients who pay no

fees for professional services to meet the necessary requirements of the departments for some of the teaching, for types of clinical investigation, and for a part of the training of the resident staff.

The staff of each large department is divided into groups, each group operating an in-patient and an out-patient service and having laboratory facilities and time for research. The organization varies with the departments and divisions, but in surgery the internes and assistant residents rotate from one group to another and are trained under the attending staff members rather than under the chief resident surgeon who operates his own service similar to that of an attending man. Also during the period of resident training each trainee spends at least one year at research.

The most important advantage of full-time group-practice for the clinical faculty is in research and the training of future investigators, since more members in proportion to the number of the staff are given the opportunity of carrying on clinical and experimental investigation than under any other existing system. With proper leadership and a good departmental organization, the basic contributions to knowledge of relatively small departments or specialized divisions may exceed those of very much larger institutions in which there is a less systematic approach to research. The accomplishments in the other educational disciplines have been of such a nature as to commend this type of organization for the clinical departments of a medical school.

The problem of working out a financial arrangement for the care of patients who pay fees for professional services that is satisfactory to both university and members of the clinical faculty is an old one, difficult of solution. The university is interested primarily in education, and prefers clinical faculty members who are primarily interested in clinical education. If a clinician uses university and hospital facilities, which are operated not for profit, to engage in private practice, and if he profits financially far in excess of his educational and research contributions in return, he may be exploiting the university or an affiliated hospital. On the other hand, if the university employs a full-time clinician on a salary to do practice, teaching, and research, all of which he may do efficiently, and in doing so he earns during the part of his time spent at practice on paying patients a sum markedly in excess of what he is paid in total salary, the university may be exploiting him. The clinical staff should not exploit the university nor should the university exploit the clinical staff. If the clinical staff adhere to the policy that their primary goal is educational, and if the university adequately supports them financially in performing the duties and shouldering the responsibilities which are called for, one of which must be the care of patients paying fees for professional services, there is no doubt, as indicated by experience, that the plan will succeed. Salaries may most fairly be based, collectively but not individually, on academic duties, professional services to patients who do not pay professional fees, and professional services to patients who do pay professional fees. The professional fees should go into a common fund to be used for the best interests of the clinical departments.

Under existing economic and social conditions in the United States, the most promising way of gradually placing education in clinical medicine on a uniform basis of organization and on an educational level that most nearly approximates the educational level of other university departments appears to be by the employment of full-time group-practice for the clinical departments of the medical school.