New Organizations Out of Old Ones: Teaching Group Practices Out of Private Practice and Outpatient Departments

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A private group practice and a traditional hospital medical clinic are joined together as a teaching group practice for primary care (Internal Medical Associates). Responsible for revenues as well as costs, the practice is administered by a board of managers composed of physicians, nurses, and administrators in the practice. This decentralization of practice from the clinical department and hospital administration has resulted in (1) a reduction in the numbers of physicians needed for the practice, (2) a greater visit census with increased physician productivity, and (3) a reduced operating deficit and better understanding of transient and educational costs. The matrix organization of the board of managers has resulted in better communication and a commitment of the staff to common goals. Public demand for a single standard of care for patients of all backgrounds, professional aspirations to work in groups, and educators' interest in training outside the hospital converge to make such reorganizations of practical necessity.

Today both private practice and hospital outpatient departments (OPDs) are reorganizing. This paper reports on an experiment in the reorganization of both. For the first time these two old forms of medical practice are joined together rather than continuing their historical separation. To do this, the OPD is defined as a group practice and its management decentralized from the departmental and administrative structure of the hospital, while private individual practice is reorganized as a group with new goals and responsibilities not only for patient care but for teaching and research. The design, rationale, and implications of the new organization are discussed.

Decentralization and Group Organization

The 1972 experiment to integrate and redefine the OPD General Medical Clinic and individual practices consisted of the following steps: (1) The outpatient medical clinics (the General Medical

Clinic, Medical Specialty Clinics, and the Ambulatory Screening Clinic) were decentralized from both the hospital and departmental administration by establishing a *board of managers* with administrative, fiscal, and professional responsibilities for their ambulatory medical patients and for teaching and research in this area. (2) At the same time a group practice, the *Internal Medicine Associates* (IMA) was formed by thirteen of the hospital's medical staff. This practice group was to be responsible for the care of ambulatory medical patients who sought general or primary care through the institution or through personal referral to the staff of the IMA. Thus the board of managers was responsible for patients in three areas: (1) the IMA, formerly the General Medical Clinic: (2) the Ambulatory Screening Clinic, a walk-in medical service: and (3) Medical Specialty Clinics. The entire group of ambulatory services was labeled the Medical Clinics Complex.

The Board of Managers

To obtain fiscal and administrative independence the board was made a profit, not a cost, center with responsibility for revenues as well as costs. To maintain its connection and coherence as a part of the larger enterprise of the hospital, the board was made a matrix organization with each member also reporting to an official in his or her functional area. Thus the board and its chairman report to the hospital's General Director, the head of the IMA to the chief of the Medical Services and the Head of Nurses to the Director of Nursing. The board is composed of members representing all groups directly responsible for care: (1) the head nurse; (2) three physicians of the IMA, one a general representative, one its director, and one a representative for teaching programs: (3) the manager; and (4) the comptroller. All members of the board are active practitioners or administrators in the Medical Clinics Comples. Making this board of working practitioners and administrators responsible for the budget and management has decentralized these functions from both the medical and nursing departments and from the hospital–OPD administration. Moreover, joining practitioners and administrators together in a management group not only permits more immediate action based on decisions made within the practice, but also provides staff participation in management. These arrangements are a distinct departure from the usual outpatient organization, which separates professional and administrative

responsibility. Traditionally, OPD administrative decisions have gone to the hospital's director and professional ones to departmental heads; since decisions about ambulatory care are rarely so distinct or separate they can be jointly made at a working level such as the board of managers, while over-all coordination with hospital and departmental policy can be achieved through relationships of board members with the department or the hospital.

Internal Medicine Associates

The group practice, IMA, was organized with four goals: (1) to develop a primary-care practice in internal medicine; (2) to integrate so-called "clinic" and "private" patients into one practice with a single standard of care for all patients; (3) to expand educational programs in primary care; and (4) to conduct research and evaluations of patient care.

In this group practice physicians work under a salary-plus-incentive arrangement based on income derived from patients they have seen. Professional charges to patients are part of clinic charges and billed by the clinic's billing department to third-party insurers and/or to patients. Incentives for productive clinical work are based on extra income generated over the basic overhead and salary income for each session of practice. The fact that staff pay overhead out of their practice reverses the university tradition that practice privileges and space are a prerequisite of university or hospital full-time appointment. The practice itself is divided into four small groups or units where three or four physicians work with a nurse-clinician, technical aide, and secretary. Except for one unit with its own social worker, the remaining units have different workers scheduled for each session.

Resident staff, medical and nursing students, work in the IMA group practice. Teaching programs include: (1) supervision of 18 interns during their weekly session in the practice; (2) a course for 80 second- or third-year students: Introduction to the Clinic; (3) a one-month elective in Ambulatory Care for one third- or fourth-year student; (4) an internship-residency program in primary care for four house staff in which 30 percent of their time is spent in the practice; and (5) clinical training for nurse-practitioners. Since all of the instruction cannot be provided by the members of the practice, other departmental staff continue to participate.

Results

Staff

As a result of this reorganization the number of medical staff working in the IMA (General Medical Clinic) has been reduced by 65 percent. Figure 1; Clinics Staffing Patterns, compares the years 1969-70 and 1972-73, since 1971-72 was a year of transition. In 1969-70, 67 visiting medical staff worked unpaid, part time, while in 1972 the number was 13, and all were paid. As staff working a half-day, weekly session, clinical fellows from the department's medical specialty units were also reduced from 50 to two. Only the house staff increased, going from 36 to 38 because of two interns in primary care. While the medical staff has been reduced, the number of support staff has risen 50 percent, from six to 12, permitting the practice to provide the typing of records and hospital billing. For the development of the primary care residency team, the nursing staff was increased from six to eight. Six nurses have completed a formal nurse-practitioner training program and now conduct one or more of their own sessions of patient care.

Among physicians, professional satisfaction with this reorganization is evidenced by the successful recruiting of staff to join the group practice; among nurses by a turnover rate near zero. Morale has been good and all staff have shown a generally positive attitude toward the changes which have been made. The matrix organizational structure has improved understanding between medical staff and administration and increased commitment to common organizational goals and objectives.

Fiscal Analysis

The reorganization was accomplished without outside subsidy for start-up costs. The responsibility of being a profit center provided an incentive to maintain a close scrutiny over the fiscal aspect of practice that has resulted in a reduction in the complex's operating deficit in the first year of 80 percent. It is hoped that the operating deficit can be essentially eliminated in the fiscal year 1974. One barrier to the achievement of this goal is the cost of teaching. On close examination, the cost of two eight-week undergraduate courses was $46,000, an amount that includes both direct expenditures and lost-opportunity costs.

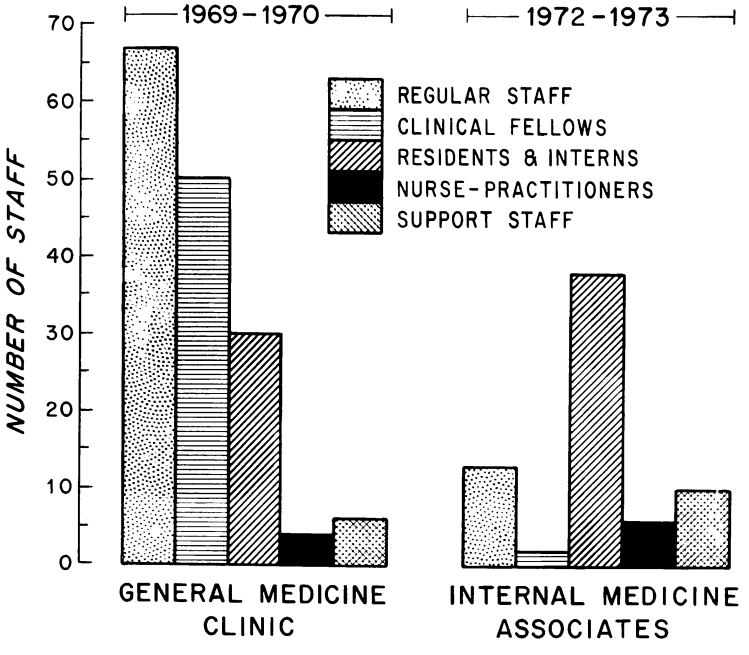

FIG. 1. Clinics Staffing Patterns

Census

During the first complete fiscal year of this new organization, the number of patient visits to the practice rose from 21,878 in 1969-70 to 24,867 in 1972-73, an increase of 14 percent due to the greater productivity of IMA physicians compared with the larger staff working under previous arrangements. Nurse-practitioner visits in 1972-73 were 2,311, or 9 percent of the practice census.

Physical Environment

Concern was expressed by some members of the staff that the mixing of private and clinic patients in clinic space would not be possible. In the year and one half of operation only two patients have refused to be treated in these surroundings. The only changes which have occurred in the physical environment has been repainting the OPD in bright colors, minor refurbishing of the furniture, and introduction of new graphics—all low-cost alterations to a building constructed in 1903.

Implications

As the interests of both individual and institutional OPD practice are again being negotiated at the hospital, a look backward at their history may suggest something about their future directions. Their common history began with the development of the OPD as a compromise between hospital trustees and private practitioners (Davis, 1927; Stoeckle, 1964). In the hospital's development as a secular institution for medical-surgical treatment, lay boards and public authorities rather than doctors became responsible for it. In exchange, private practice retained responsibility for care in the community. In its domain beyond the hospital, private practice permitted only three non-private group practices: OPDs, public health clinics for special diseases (e.g., tuberculosis, venereal disease), and health centers (Stoeckle, in press). Access to these, however, was restricted to the "sick poor" who "could not afford a private doctor," a compromise agreement, in the case of the OPD, between hospital trustees and private doctors. In exchange for the control of practice in the community, the doctor permitted the OPD; in exchange for hospital admission privileges for his own patients, the doctor provided professional care in the OPD on a voluntary basis.

Because of these familiar historical circumstances, the OPDs had organizational features distinct from individual practice, namely, low-income users who paid limited charges; part-time, unpaid medical staffs; and a hierarchal administration that separated the staff from the management of practice. Unlike private practice, OPDs were also responsible for teaching. When private practitioners did teach it was away from their own offices in the hospital or OPD. Such features made OPDs' deficits, inefficiencies, and discontinuities of care inevitable. Spared from deficits, part-time group organization, and teaching responsibilities, private practice was solvent, less expensive, and efficient. Differently constructed, these two practices have continued as separate organizations, but they no longer meet the complex of needs and expectations emerging today.

Patients expect efficient personal ambulatory treatment wherever they seek care. Physicians aspire to work in groups and participate in management. New educational and public interests in primary care require ambulatory practices that will include patients of all backgrounds whether "private" or "clinic." By pro-

viding care from the same physician at significantly less cost per visit than most OPDs, individual practices meet some of these expectations and needs. When income depends directly on the care they provide, practitioners also have an incentive to provide personal care; moreover, they also have the managerial responsibility for it. Neither the OPD nor the practitioner has less "desire" to provide efficient, personal care. But in the OPD, the practitioner has little managerial responsibility or work incentive to do so. He does not hire or supervise the support staff, set policy, or organize treatment, not is he dependent on the success of the OPD practice for income, "status," or "promotion." Similarly, when practitioners are "volunteers" and when staff and budget decisions are dependent on the hospital departmental administration, the position of the OPD "administrative" staff is like that of the doctor. The OPD administration controls neither the providers of care nor the economic management of the practice.

Most hospital OPDs have not met this mix of professional, public, and patient needs, while individual practice cannot meet the expanded needs of teaching or the new aspirations of physicians for working in groups. Over the last twenty years, several minor accommodations in the two practices have, of course, improved ambulatory care at the hospital: (1) the location of individual practice on hospital grounds providing group affiliations without formal organization (Vahovich and Aherne, 1973:166); (2) the use of non-physician health workers in OPDs (Stoeckle and Twaddle, 1974); (3) the employment of physicians to manage emergency rooms and clinics (United States Department of Health, Education, and Welfare . . . ;1971); (4) the reduction of OPD staff to paid physicians only, namely residents; and (5) the expansion of diagnostic and laboratory services for outpatients. For major changes to occur, both physicians and hospital administrations must construct practices which provide primary care and specialized ambulatory services meeting a single standard of high quality for patients of all backgrounds. This goal now seems more possible as the public demands it, as physicians show increasing interest in group practice to ease work pressures and to gain closer intellectual interaction with their colleagues, and as educators are interested in designing more training and education along the ambulant rather than the exclusive hospital mode of services.

To achieve such quality services, hospitals and clinical departments with greater interest in ambulatory care are willing to decen-

tralize management and fiscal responsibility. However, to achieve such goals, mutual accommodation is also required. Medical staffs must agree to become a part of the hospital structure that may require working under some guides on professional and treatment policies, for example, making teaching a responsibility of practice. The hospital, in turn, must give the staff sufficient independence, both administrative and fiscal, to allow their need to manage their own practice settings. Finally, additional economic support for education and research must be provided.

The reorganization described has been designed to begin these changes.

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