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REPORT OF A SURVEY OF THE GROUP MEDICAL CLINICS SERVING BENEFICIARIES OF THE UNITED MINE WORKERS WELFARE AND RETIREMENT FUND IN THE PITTSBURGH AREA

EDITORIAL PREFACE:

Dr. Weinerman prepared this lucid, analytical report 12 years ago, (it has not been published previously,) and its parameters of concern are as appropriate for evaluation today as they were then. Time has confirmed the validity of his concepts.

The three Clinics studied state that Dr. Weinerman’s analysis served to inspire and focus the activities and efforts of the health workers in the area. His visit also provided essential insights of a conceptual nature and communicated an appreciation of the historical significance of the efforts devoted to progressive changes.

In the past 12 years substantial changes have occurred and more continue to evolve, resulting in no small measure from the Weinerman report. Increased emphasis has been placed on the role of full-time physicians to provide the bulk of services. The full-time staff has increased while the part-time staff has diminished substantially. There is increasing orientation to long-term and preventive health needs of the patients, with a broadened range of services in the office and in a coordinated home health program. The skills of staff members of the health team are being used at a much higher level with professional nurses assuming an increasing role in the delivery of primary health care, health aides enlarging their sphere of services, and the social worker, physical therapist, benefits counselor and others providing services not previously available.

Despite many difficulties, which always accompany attempts to create social change, the three Clinics surveyed by Dr. Weinerman have responded positively to his constructive criticisms and have improved and made more comprehensive their patient-care services. Most significantly, the model of progressive medical care provided by the Clinics and their staffs are producing a growing impact on the pattern of medical care in the whole area.

I am enclosing my “report.” The gingerly handling of this term stems from the fact, as you will see on first reading, that it is essentially a first draft—a sort of narrative remembrance, unencumbered by supportive statistics, details of observation or recommendations, with fairly loose organizational structure. However, I do hope that it can serve as a reminder and basis for discussion regarding the various points made during the survey.

I do hope that some of the more critical remarks will not be taken in any spirit other than the one of sympathetic understanding which I truly feel in respect to the efforts being made by all of you.

E. R. W.

INTRODUCTION

The survey

A survey of the quality of medical care provided by the Russellton, Centerville, and Bellaire Medical Clinics serving the Pittsburgh area of the UMWA Welfare Fund Medical Program was conducted in October, 1959
at the invitation of the Administrators and Medical Directors of the three clinics, with the concurrence of Area Medical Office personnel. The limited amount of time available for study of these complex and geographically dispersed programs required a sharply circumscribed survey plan and objective, as described below. Although a considerable part of the reporting of observations and recommendations was accomplished through oral presentations and discussions during the field visits, this report is submitted as a brief summary of those observations which appear to the surveyor to be the most important.

At the outset, the decision was made to concentrate primarily upon the quality of medical care as reflected in the organization and effectiveness of health services—rather than in details of clinical practices, statistical analyses, administrative techniques, or patient interviews. The following were the successive stages undertaken in the survey effort:

1) Review of available information regarding the UMWA Welfare and Retirement Program and data provided by the local clinics.
   2) Construction of an Appraisal Guide.
   3) Preliminary conferences with Area Medical Office personnel and with Administrators and Medical Directors of the individual clinics.
   4) Interviews with representative medical, nursing, technical, administrative, and consultative personnel.
   5) Field observations of clinic and branch facilities, equipment, patient care, medical records, administrative records and forms, library resources, professional staff conferences, ward rounds, and special health education activities.
   6) Analyses of selected statistical materials and of random samples of medical records.
   7) Conferences with Board and Union members.
   8) Discussions with the full medical staff in each clinic and with leadership personnel conjointly with area and national Fund representatives.
   9) Coordination and evaluation of data collected and observations made, with subsequent oral and written reports.

Criteria of evaluation

The focus of the study was on the effectiveness of health protection afforded the participating members and their families. Thus, the criteria of evaluation were patient—rather than doctor—oriented, focused on health conservation rather than management of illness, related to organizational rather than clinical methodology, and reflective of theoretical concepts held by responsible program leaders rather than of operating statistics.
Within this special framework, the plan of observation in each local program was as follows:

1) "External" factors affecting the program
   i.e.: Political, geographical, financial, medical, hospital, cultural, etc.

2) UMWA Welfare Fund policies affecting the program
   i.e.: Official policy re benefits, payment methods, eligibility, etc.: Area Medical Office policies and practices; etc.

3) Local program factors
   a) Administrative controls of quality
   b) Professional and auxiliary personnel
   c) Physical facilities, equipment and supplies
   d) Professional staff organization
   e) Continuity and coordination of health services
   f) "Amenities" of patient care
   g) Clinical practices
   h) Medical records
   i) Education and research activities
   j) Attitudes and motivations
   k) Prevailing concepts regarding high quality of medical care
   l) Objectives of the program; stated and observed

The "concept of quality" utilized in this survey gives special emphasis to such aspects of medical care as the following:

1) Scope of services available
2) Balance of services provided
3) Timeliness of services rendered
4) Barriers to needed services
5) Pertinency as part of adequacy of "work-ups"
6) Diagnostic rather than symptomatic therapy
7) Continuity of individual patient care
8) Coordination of successive phases of care
9) Central responsibility for personal and family care
10) Appropriate use of consultation and referral
11) Application of organized methods of prevention and rehabilitation
12) Consideration of social and psychological aspects of illness and patient care
13) Quality of the physician-patient inter-relationship
14) Membership information and education efforts

Such then, are the characteristics of this particular survey effort and the frames of reference used in the critical evaluation.
GENERAL OBSERVATIONS

The overall view

This intensive period of observation, undertaken in a spirit sympathetic to the objectives of the program yet objectively critical in appraisal of current practices, left the surveyor profoundly impressed with what he saw. The vision and courage of the Area Medical Administrator in the conception and development of the program, the ability and dedication of the professional and administrative clinic leaders, the very existence of competent and carefully organized modern medical services in these isolated coal mine communities—all were deeply impressive. Perhaps the greatest impact stems from the fact that these three clinics are demonstrating—under exceptionally difficult circumstances—the validity of the “progressive” medical care concepts of group practice, regional integration of facilities, prepayment of costs and democratic policy control.

It is in this context—admiration for the basic accomplishments and appreciation of the enormous difficulties involved—that the appraisal efforts are reported. A striking feature of the survey was that few of the critical observations were not either well understood by the program leaders or already in the process of correction.

Factors affecting quality of care

Any assessment of the operating program must differentiate carefully among “external” factors, UMWA Fund policies, and characteristics of the local operations. While this survey was limited to observations of local clinic activities, the impact of the former two sets of influences was continuously apparent.

The “external” problems have been severe enough to have jeopardized the initiation, continuation, and effectiveness of the entire program. Political pressures have involved the community, the Union, the Welfare Fund, the medical profession, hospital authorities and the program personnel themselves. The geographical factors of isolation, distance, transportation, terrain, etc. are significant. Financial limitations affect the adequacy of physical facilities, personnel recruitment, scope of services and administrative planning. Cultural barriers interfere with the essential “rapport” between staff and patients, restrict educational programming, and limit community acceptance of the new services.

Perhaps the most damaging has been the opposition of State and local medical authorities, resulting in effective sanctions against participating physicians, denial of hospital privileges, ostracism from professional activities, etc. All in all, the external odds have been so great that most of the
recognizable weaknesses of the programs have been literally enforced upon it.

Similarly crucial to an objective evaluation of the clinic performance is an understanding of the effect of UMWA Fund policies and directives. The exclusion of ordinary home and office medical services, the particular definition of eligibility, the emphasis upon specialist and hospital care, the essential fee-for-service nature of the payment mechanisms—all directly condition the specialist-oriented structure of the local programs. In addition, the local clinics reflect a kind of loneliness which stems from the necessary pre-occupation of the Area Medical Office with the complex demands of the overall Fund operation. Optimum regional coordination of activities among the three field operations also awaits greater emphasis in Pittsburgh.

Despite these powerful "outside" influences, however, a tremendous variation can and does exist among the three local programs. Many differing strengths and weaknesses are apparent, and—in the opinion of this surveyor—the potential for significant improvement in the quality of medical care lies within the organizational framework of the program itself.

Specific assets and accomplishments

In addition to the basic achievements of the clinic programs—those of meeting real medical care needs in the coal mine communities and demonstrating the value of properly organized group practice services—a number of specific accomplishments deserve special mention:

1) The method of partnership organization in the three medical groups. The equality of partnership voice and status among all full-time physicians (regardless of specialist qualifications) and the elimination of income differentials between surgical and non-surgical practitioners form the basis for mutual respect and allegiance in any medical group.

2) The development of representative and interested "consumer" Boards of Directors. This is the corollary of democratic staff organization, and assures the representation of the patients' interest which is so important for medical care of good quality.

3) The development of unit record systems, with imaginative use of locally adapted forms and folders. The thread of continuity in any health plan involving numerous doctors and scattered facilities is the central medical record, and this aspect of group practice has been carefully thought out in the clinics visited.

4) The emphasis upon continuing professional education. The visitor is impressed by the emphasis given to regular medical conferences and "rounds," as well as the formal recognition of the value of paid time off for attendance at outside professional educational programs. Only in this way, of course, can standards of care be maintained.
5) The deep interest evidenced by all concerned with the improvement of quality of care. This all-important matter of motivation for high standards was reflected in the very request for this survey, the critical self-evaluation constantly in process, the plans for continuing medical “audits,” and the unusual concern about standards expressed in all staff conferences.

Critical observations

It is easy to find flaws in performance in any one else’s program—especially in medical care projects which are pioneering in the face of enormous difficulties of location, financing and professional hostility. The following comments on relative weaknesses in the observed activities are submitted with sympathetic understanding of the history of the program and in the effort to focus attention upon those aspects of organization and planning which seem to be largely within the ability of the local clinics to handle. Obviously, too, the many small details of administrative or medical procedure which were observed during the survey and discussed in the field need no further reporting here. Since the focus of the study was on the organizational aspects of health service, the following comments relate mostly to this phase of the program.

1. Central responsibility for patient care; continuity and coordination of health service.

The primary weakness of the program relates to a distortion common to most American clinic or group medical structures (and conditioned by the benefit policies of the UMWA Welfare Fund)—namely, the over-emphasis upon “central” specialist services and the converse starvation of the “peripheral” general or personal medical care. In most of the service areas—particularly in the Centerville and Russellton Clinics—the competent, well-equipped and carefully functioning central specialist group contrasted strongly with the isolated, ill-equipped, often-harried “G.P.” Thus, the “community office” becomes a combination of first aid station, prescription-writing service, and way station for patients en route to specialist examination.

As observed during the survey, the outlying G.P. does few case “work-ups,” practices essentially symptomatic rather than diagnostic medicine, has irregular contact with consultants, and maintains only variable continuity with his patients. These problems are less acute for those general practitioners working in the central clinic facilities, but even here existing policies result in not too dissimilar patterns. Appointment systems were rarely seen (for G.P.’s), with time for patient visits dictated by waiting room pressures and inadequate total scheduled hours. Basic laboratory, diagnostic, and ancillary personnel resources were inadequate in most of the branch facilities.
Efforts at preventive service, health education, laboratory screening, attention to psychological and social factors, etc.—so well emphasized by many of the central specialists—were seemingly not considered in relation to the community offices.

Despite the fact that formal UMWA Fund benefits cover only specialist and hospital services, much can be done to orient the clinic services toward patients and health, rather than specialists and episodes of illness. The vast majority of contacts between the program and its members occur at the personal physician—not the specialist-level. It is here that all possible strength must be mobilized—for preventive and educational services; for establishment of the personal health record; for continuity of long-term care; for coordination of specialist, hospital, laboratory, and other services. *Definite appointment scheduling* for at least some of each day, can permit the personal physician to plan the continuity of his care, to complete "work-ups," to organize his professional day. Every administrative resource should be employed to safeguard maximum continuity of the established *doctor-patient relationship*.

The basic specialists—internal medicine, pediatrics, and, perhaps, gynecology—should be scheduled in a *definite rotating plan* to see referred patients in the community offices and, if possible, in some direct personal relationship to the referring physician. Basic screening and simple diagnostic *laboratory and X-ray facilities* must be available where the personal care is maintained. Wherever possible, the personal physician should be part of the *hospital care team*.

If effective doctor-patient relationships and continuity of health care are recognized as essential to high quality in group medical service, the role of the personal doctor in the group structure needs re-definition. Thus, there should be *one primary basis for his practice*—whether in the outlying office or the main clinic—rather than a rotating schedule of "sick call" in various places. His role as closely-integrated group member is not lost if there is: (1) continuous contact with rotating consultants, (2) regular participation in conferences, rounds, partnership meetings, etc. at the center and hospital, and (3) scheduled, voluntary attendance at selected specialty clinics of interest to the general physician.

2. *Appropriate use of specialty consultation and referral services.*

The opposite side of the coin of anemic personal physician service is the inefficient over-use of specialists. The survey revealed, in all three clinics, a pattern of excessive specialist referral; utilization of qualified internists for the establishment of "ordinary" illness; referral to gynecologists for routine
pelvic examinations; maintenance of rather luxurious appointment systems and small patient loads by internists and pediatricians—largely because of the absence of a personal physician system with prior establishment of basic health records, appropriate referral and follow-up patient responsibility.

(This is not to deny that all physicians—specialists and generalists alike—must develop adequate work-ups, take sincere personal interest in their patients as persons, and consider all social and environmental aspects of the medical problem. It merely emphasizes that fact that a proper base of informed and continuous personal physician service makes possible the most effective level of specialty care.)

Available statistics on weekly patient load per specialist indicate unusually light scheduling, especially at Centerville, for internists and related specialists—due chiefly to long appointments for routine medical student-type work-ups and to rather generous allowances for hospital rounds. This pattern has been maintained even in the face of shortages of internists and pediatricians and long waiting periods for patient appointments. In contrast, patient loads per “session” have been high for such fields as dermatology, allergy, and ENT.

In this connection, careful distinction is urged between the concept of the basic health record and that of the diagnostic work-up. The former should be established for every new patient by the personal physician who is to be responsible for continuous health supervision—but not necessarily (perhaps not even desirably) at the first visit and not necessarily in one session. This is “person-oriented,” and produces a basic record of all significant personal and medical information. In contrast, the consultant’s examination, typically performed by the internist, should be selectively and pertinently diagnosis-oriented, building upon and specifically enlarging upon the basic health record data. The traditional long, detailed and stereotyped format used for medical student indoctrination is not necessarily a high standard for the mature, consulting specialist.

Such a “proper” generalist-specialist relationship would make obvious the appropriate level for laboratory screening procedures.

These observations do not pretend to suggest any answer to the difficult question of what category of physician should be the front-line personal doctor. The answer will probably be found in the development of a new model of “managing physician” for group practice—part way between today’s G.P. and internist. Whether the temporary solution is the health-oriented generalist (omitting major surgery and complex obstetrics) or the broad-gauged internist-pediatrician team—the concept of careful, continuous patient responsibility is the key.
3. Use of auxiliary personnel.

In some respects, a general tendency was apparent in all the clinics toward some “down-grading” of professional function. Thus, consulting internists were busy compiling routine health records, general physicians often functioned without help in clerical and nursing procedures, professional nurses spent much of their time performing routine tasks such as routing patients, cleaning examining rooms, etc. The opportunities present in clinic organization—so difficult for the private solo practitioner—for use of “newer” health skills such as public health nurse, social worker, health educator, etc. were seldom exploited.

The need here is to protect the maximum efficiency (and economy) of professionally trained personnel by appropriate use of ancillary aides. RNs can perform valuable service in patient care, medical assistance, patient guidance, control of drugs and equipment, etc.—if they supervise trained aides for routine functions. A single public health nurse in each clinic program could do much to develop preventive and educational services, as well as fuller use of community health resources. The medical social worker has equally valuable contributions to make to the group practice clinic, in terms of social diagnosis and therapy, interpretation of medical needs, family and job relationships, liaison with other agencies, etc.

4. Use of medical audit.

Despite high ideals and qualified personnel, the long-term maintenance of good quality of care requires continuous self-surveillance and self-improvement. The well-tested concept of routine, semi-statistical analysis of medical records, as a reflection of medical work, is an important tool to the “out-patient” clinic as well as the hospital staff. Interest in such audits was expressed by each of the clinic groups, with most advanced planning observed at Russellton, although regular reviews were not yet underway.

In the development of audit programs, three recommendations are offered: (a) Detailed procedures should be tailored to the local program rather than borrowed intact from other institutions. (The draft outlines at Russellton and Centerville are excellent starts.) (b) The entire medical staff should participate in the record analysis, rather than the chiefs of service alone—for obvious educational and stimulatory reasons. (c) While problems involving individual physicians are matters for private discussion and correction, the pattern of weaknesses or errors should be made the basis for the regular staff educational programs.

5. Conduct of effective staff education activities.

Devotion to the concept of continuing professional education is impressively demonstrated in each of the groups. At the present time, the best staff
conferences seem to be those at Bellaire, while hospital rounds at Center-ville were also excellent. Some suggestions may be helpful, however, for enhancing the general effectiveness of the staff education activities.

Since those who prepare and present the conference material benefit the most, the ideal program is one in which the least informed and experienced staff members are regularly involved in the presentations or discussions. Whenever possible, educational sessions should take up the local problems faced by the group, rather than only general topics of theoretical interest. Conferences should be held away from the patients' presence, with maximum use of visual aids, and with equal status in discussion for all group members. The educational meetings should be scheduled and designed for the maximum participation by outlying general physician members of the staff.

6. Development of preventive services.

Although interest in preventive medicine was well demonstrated during the survey (particularly at Russelton), and although opportunities for specially organized preventive services are far greater in prepaid group practice than in private solo practice, little real progress has been made in this area. (Exceptions to this criticism are the unusually fine series of classes for diabetics and the school health plan developed at Russelton, the interest in multiple screening at Centerville and the emphasis upon well-baby and prenatal care at Bellaire.)

Suggestions for a preventive program might include the following:

a) Health promotion
   1) Regular membership bulletin—for both health education and program information purposes
   2) Periodic membership meetings planned around health subjects of general importance
   3) Distribution of carefully selected written and illustrated materials in clinic facilities
   4) Fuller use of health promotional resources of local public health agencies
b) "Primary" prevention—avoidance of preventable disease
   1) Full immunization campaign, with careful maintenance of "shot" records and follow-up controls
   2) Specially organized and scheduled well-baby, prenatal, and postnatal conferences, utilizing the public health nurse
   3) Special medical supervision of miners exposed to occupational pulmonary diseases and close liaison with industrial health and mine safety personnel
c) “Secondary” prevention—early detection of disease and avoidance of unnecessary complications
   1) Periodic multiple laboratory and X-ray screening of apparently healthy members
   2) Establishment of an adequately detailed Personal Health Record for all registered patients
   3) Appropriate and pertinent use of cytological smear techniques, periodic chest X-rays, tuberculin tests, sigmoidoscopy, tonometry, etc.
   4) Encouragement of periodic health “check-ups” with specific appointment schedule. Special birthday reminder cards, etc.
   5) Special procedures of follow-up for patients who lapse in treatment
   6) Emphasis on importance of breast, pelvic, rectal, lymph node, and testicular examination during work-ups and periodic health checks (Important items for medical audit)
   7) Use of long-term preventive techniques such as anticoagulant therapy in chronic vascular disease, penicillin prophylaxis in rheumatic disease, allergin control procedures, etc.

d) Preventive rehabilitation—avoidance of needless disability
   1) Early mobilization and functional activity in “stroke,” metabolic disease, surgery, geriatric problems, etc.
   2) Application of physical therapy techniques early in acute illness as well as injury
   3) Attention to patient needs for mental stimulation, purposeful activity, self-care, psychological security, personal dignity, etc.
   4) Maintenance of properly equipped and staffed physical therapy department under trained physiatrist supervision

7. Application of administrative controls of quality

A number of administrative and statistical procedures have been tested in other medical care programs for the protection and reflection of quality standards. The continuous medical audit and periodic “spot” check of medical records fall into this category. Other suggestions include the following:

a) Requirement of prior authorization (by Medical Director, Chief of Service, Specialist, etc.) for selected items of diagnosis or therapy. (i.e. use of long-term corticosteroids, elective hospitalization, use of “outside” consultant, etc.)

b) Establishment of regional standards and controls by Area Fund Office (see below)

c) Development of selected medical procedure manuals
d) Creation of Professional Advisory Board, made up of professional experts not participating in the program, for establishment and maintenance of standards

e) Use of specially collected program statistics for analysis and control of professional work, e.g., membership utilization rates, patient load, unit costs, consultation and referral rates, hospital admission rates and length of stay, "no-show" and cancellation rates, autopsy rates, turnover of personnel, laboratory tests per diagnostic categories, etc.

Role of Area Medical Office of UMWA Fund

The existence of three group practice programs in functional relationship to the Pittsburgh center, operating under the same general financing and policy plan, sharing overall concepts and objectives—leads inevitably to the question of why meaningful "regionalization" of services has not been more fully developed. Here, the Area Medical Office has a potentially important role to play, over and above its present excellent administrative functions. These may be outlined as follows:

1. Establishment of quality standards regarding personnel, facilities, services, etc. as a part of the contractual agreement with the local medical groups.

2. Provision of regular and "on-call" consultation to the local clinics in medical administration, business management, nursing, laboratory and X-ray service, personnel management, etc.

3. Organization of selected "super-specialty" consultants to serve all three local group programs such as neurosurgeon, physiatrist, health educator, etc.

4. Arrangements for special diagnostic or treatment services in Pittsburgh for use by the local groups—i.e. special pathology, chemistry, electroencephalography, radiation or isotope therapy, etc.

5. Continuation and extension of current periodic conferences of local clinic representatives.

6. Development of comparable statistical indices for the three local programs as the basis for inter-group comparisons and improvements.

7. Regular visits by Area medical, nursing, and administrative representatives to the local facilities.

In these and other ways, the Area Office could contribute to the quality of care in the group programs and also create a true regional organization of services uniting the separate facilities.

OBSERVATIONS RE INDIVIDUAL PROGRAMS

In view of the general objectives of the survey, it is not possible to report on details of operation in each of the three groups. It may be useful, how-
ever, to point out a few of the more important strengths and weaknesses which pertain to the individual clinics.

In the opinion of the surveyor, there are three key factors which determine the essential differences among the three operations, in addition to obvious local influences such as geography, community relations, hospital privileges, etc. These "index" factors are (1) the theoretical concepts regarding program goals held by the medical and administrative leaders; (2) the technical and physical resources at their disposal; and (3) the way in which the monies received from the UMWA Fund are applied. (That portion of payments from Fund to clinic which exceed, as they must, unit costs for these services under group practice arrangements—leaving certain amounts available for other application within the total program.)

In general then, the following summary may be offered:

1. Russellton reflected the clearest theoretical conceptualization, had the poorest material resources, applied the "surplus" primarily to the financing of a large number of part-time specialists.

2. Centerville expressed program objectives most at variance with the criteria used in this evaluation, enjoyed the most favorable material resources, and consumed the "surplus" in a relatively low case-load for its full-time medical staff.

3. Bellaire reflected an intermediate theoretical and material position—although closer to Russellton in the clarity of concept and to Centerville in adequacy of facilities. Here, the "surplus" appeared to be applied primarily to the subsidization of the modest private patient fee schedule in the clinic.

One other overall parameter of comparative evaluation may be offered: the degree to which the program as currently observed approaches the ideal of group medical practice and continuity of patient care. Within the limitations described in detail above, it would appear that the Bellaire program comes closer to the objective than do the other two.

More specific observations in each locale may be summarized as follows:

A. Russellton Clinic

1. Strengths
   a. Integration of general physicians into the medical partnership structure
   b. Efficiency and clarity of administration
   c. Use of available community health resources
   d. Design and use of unit medical record forms
   e. Experiments in health education
   f. Interest and planning in preventive medicine
   g. Interest and planning for continuous medical audit
2. Problems
   a. Inadequate physical facilities, even in terms of the limited material resources of the two other programs.
   b. Large numbers of part-time specialists—with relatively high unit costs and variable identification with problems and goals of the medical group.
   c. Excessive rotation of GP's between the central facility and outlying offices; no organized appointment system for these physicians—with resulting lack of continuity of patient care; inadequate health records, etc. Another consequence of this structure is a relatively high turnover of GP's and some weakening of their identification with the medical group.
   d. Relatively low patient load in internal medicine and pediatrics—reflecting the inadequacy of the general physician service as discussed above.
   e. Over-referral to specialists (some 45% of cases), again reflecting the "sick-call" type of GP care.
   f. Lack of adequate coordination of medical records between the central clinic and the outlying offices.
   g. Summaries of hospitalization of clinic patients not always in the clinic medical records—aggravating the existing difficulty of the complete lack of hospital privileges for full-time group physicians.
   h. Apparently weak role of lay Board of Trustees.
   i. Relatively low level of utilization of clinic services by eligible families in the area—reflecting the many problems of medical society antagonism, limited union support, weak membership information program, cultural barriers, geographic factors, etc.

B. Centerville Medical Group
1. Strengths
   a. More nearly adequate physical facilities.
   b. Highly qualified, essentially full-time medical specialists.
   c. Impressive organization of hospital service in view of grossly obsolete hospital plant.
   d. Excellence of medical records.
   e. Well organized and conducted professional education program.
   f. Active and supportive Board of Trustees.

2. Problems
   a. Over-emphasis on specialized consultant services—organized in
pattern of university teaching clinic, not necessarily in the best model for prepaid health service in the dispersed mining areas.

b. Relative isolation and separation of GP functions, viewed essentially as feeder stations for the central specialists. No organization for concept of effective and continuous family health care by the personal physician.

c. Unusually low patient loads in internal medicine and some other specialties (as low as 20 patients scheduled per week), excessive time allotted for hospital rounds—despite long waiting periods for clinic appointments (up to 3 and 4 weeks) and alleged need for more staff interns. Low daily patient loads and relatively short office hours noted also for general practitioners.

d. Efforts at laboratory “screening” and establishment of detailed patient health record applied at wrong level of care—that is, at specialist rather than personal physician level.

e. Inadequate rotation of center specialists to outlying offices.

f. Excessive use of laboratory and X-ray services and relatively long hospital stays for UMWA patients.

g. Location of central clinic not well related to main population areas, public transportation routes, usual lines of trade movement, etc.—with resultant barriers to referral from community offices.

h. Factors of transportation, long waiting times for appointment, lack of personal consultation reports, isolation of GP’s from specialist members of the group—all contribute toward falling rates of referral to the center (actually lower in 1958 than 1956).

i. Inefficient use of nurses: no supervisory nurse free of routine duties, use of RNs for menial aide-type work, no public health nursing service, etc.

j. Lack of serious planning for continuous medical audit involving all group physicians.

k. Inadequate understanding by the medical staff of the role of vigorous and adequate administration; currently understaffed and weak business management and administrative program control.

C. Bellaire Medical Group

1. Strengths

   a. Well-integrated and democratic medical group structure. Excel-
lent coordination of general and specialist physicians within the group.
b. Efficient concept of "regional" program planning, as reflected in design of operations in the new Harrisville and Powhaten clinics.
c. High quality of patient care, reflected in good medical records.
d. Strong protection of GP function—with adequate appointment scheduling, continuity of patient responsibility, close consultation relationships, participation in hospital service, etc.
e. Effective medical staff conferences, with participation of GP's on equal status basis.
f. Effective cooperation between medical and administrative staffs.
g. Recent organization of an interested and able lay Board of Trustees.

2. Problems
a. Evidence of rigidity in concept and structure of medical service; tendency to "all-or-nothing" approach to possible program improvements. Related is a degree of over-emphasis upon the principle of medical group "unanimity" in policy determination.
b. Maintenance of actual "cut-rate" private medical fees, with subsidization by the overall Fund budget, in order to attract community patronage at the going rate for local solo practitioners.
c. Partial rotation of GPs from community clinics to the central facility for "drop-in" service, while no general physicians function in the Bellaire center. Resulting confusion between role of personal doctor and consultant on the part of internists and pediatrician.
d. Inadequate emphasis upon preventive medical service.
e. Relatively distant relationships with the Area Medical Office in Pittsburgh.

CONCLUSIONS
In summary, the overall program can be described as an outstanding example of initiative and imagination in the application of progressive concepts of medical care organization. Despite seemingly insurmountable barriers of medical opposition, geographic isolation, inadequacy of physical facilities, financial instability, etc., a full scope of modern medical service of good quality has been brought to the coal mine communities of the region. The basic strength of the program lies in the orientation and dedication of its leaders, the adherence to the concepts of prepaid group practice with regional coordination of facilities, the active participation of local union representatives, and the support of the UMWA Fund personnel.
The aspect most in need of improvement is that which relates to the general physician service; its proper relation to specialist, laboratory and hospital care; its potential for continuity of patient care, preventive medicine, early rehabilitation and health education. High standards of care in the program will be protected, over the long run, by improved techniques of professional education, critical self-evaluation, and administrative controls of quality. A strong consultative role assumed by the Area Medical Office is the essential cohesive factor.

A major task facing this and every group practice service is the better definition of the personal or managing physician—his qualifications, training requirements, prior experiences, and role in the medical group. With the solutions of these problems will evolve the definitive standards for medical care of real effectiveness in prepaid group health service.

Perhaps, the essential need is for continuously sharper orientation of the program toward patients rather than doctors, toward health rather than disease, toward new organizational forms rather than traditional patterns of the university center, and toward reliance upon appropriate theory as well as operational experience as the guide to the future.