Group medical practice as an innovation depends for acceptance or rejection on how those involved in it perceive it. If these perceptions conflict with the individual's behavior and ideas, there is clearly a need for understanding and action.

Provision of Medical Care

History • Sociology • Innovation

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WHEN the Committee on the Costs of Medical Care published its final report in November 1932, the majority submitted a program with five basic recommendations. The first of these proposed "that medical service, both preventive and therapeutic, should be furnished by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel. Such groups should be organized, preferably around a hospital, for rendering complete home, office, and hospital care. The form of organization should encourage the maintenance of high standards and the development or preservation of a personal relation between patient and physician" (*1*). The more sanguine proponents of this course of action felt that group medical practice was a logical and reasonable step toward improved organization and provision of medical care, and that it would spread rapidly. But this did not happen.

Organizations designed to provide medical care through some form of group practice have developed slowly but steadily in the intervening 25 years. Some have been organized by consumers using the Rochdale principles of cooperation. Others have been created by groups of physicians in noninsured practice, by labor unions, and by groups in the community who wish to make comprehensive medical care available to low- and middle-income groups. A number of these are associated with prepayment plans, notably with the Health Insurance Plan of Greater New York and the Kaiser Foundation Health Plan.

Recently, questions have been raised concerning the slow growth of such plans, and critical views have been expressed on the gap between promise and practice in group medical care (*2–4a*). These critiques have highlighted certain painful inadequacies and have focused attention on the importance of solving these problems, but the proposed remedies tend to concern themselves with surface manifestations or to dissolve in hortatory admonitions. In a discussion of the quality of medical care at the recent National Conference on Labor Health Services, one participant remarked: "When people leave a group practice program to join a fee-for-service plan . . . the gauntlet has been thrown down to the service plan. There must be reasons for this, because workers generally reflect the degree of satisfaction with the serv-

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ice" (*4b*). And while the speaker conceded that there may be multiple reasons, these apparently derived simply from the lack of "the amenities, the niceties, the timeliness, the promptness, the personal touch," or something desired by the patient. There is no apparent appreciation that such phenomena may be symptomatic of more deeply rooted causes. Furthermore, while this speaker and others dealing with this problem give evidence of an empirical awareness that medical care is a social activity organized in certain institutional forms, there is no reference to the existence of a body of scientific theory and knowledge which may throw light on the problems previously indicated, and perhaps point to ways of mastering them.

Medical care in some form has been an element of group living throughout history, and in all likelihood long before recorded history. Moreover, as a social function it is integrated and interlocked with other elements in the structure of group living of which it is a part, with government, the economy, the family, religion, and others. All human actions must be studied within a framework conditioned by men, with an understanding of men's ideas of the present and hopes for the future. Historical continuity derives from common challenges and purposeful responses to meet these challenges. One such constant has been the continuing search for security from the unpredictable impacts and hazards of ill health and its concomitants. Another aspect of continuity is the human aspiration toward self-fulfillment, the individual's need for self-expression. Such needs may reinforce each other or run counter one to another, thus creating tensions. The result is a variety of actions and reactions under differing circumstances and in widely divergent ideological climates. Yet these actions and reactions provide a pattern which makes possible an understanding of behavior and process. For a major contribution of historical analysis is to penetrate the process of development. Institutions, patterns of behavior, systems of ideas, methods of control—all have developed from something which was there before. The hospital, the health department, fee-for-service medical practice, the theory of animate contagion—all illustrate this truism which is too often forgotten. For these reasons it may be useful to consider group medical practice in historical and sociological terms, and to see whether historical analysis and sociological investigation may not enhance our understanding of its present condition.

Sociology, History, and Medical Care

The provision of medical service is an activity involving interaction between two or more human beings, thus creating a social system. At the same time, the participants in this system are also members of other larger and smaller social systems, which form the greater part of their environment, and which exert a determining influence on their thought and action. Without knowledge of this environment, the behavior of the physician, of the medical profession, of the patient and his family, and of others involved in the provision of medical care cannot be fully understood and taken into account in changing traditional ways of providing medical care and adopting new forms for this purpose. Within this environment, there is a social order characterized by differential distribution of power, accessibility to ways of earning a living, prestige, and status. The participants in this order have defined roles, specified behaviors considered appropriate to these roles, and values which motivate or are presumed to motivate the participants. Associated with this system, supporting it and interlocking with it, are complexes of knowledge, techniques, beliefs, values, attitudes, norms, symbols, rituals, and customs. Some of these are shared widely in a society; others are the concern of smaller groups.

The medical profession, like other occupational groups, has a body of shared ideas, values, and standards. Members of the profession are expected to orient their behavior in relation to patients, colleagues, and the community at large in terms of norms and values generally accepted and agreed upon. Many of these ideas and behavior patterns have been transmitted from the past and are adhered to even though the situation has changed radically. Adherence to systems of inappropriate or incompatible values and norms is not peculiar to physicians; it is characteristic of other

groups as well. Nonetheless it remains a phenomenon to be taken into account in studying the development of new methods for providing medical service.

Medical Ideology and Practice

The physician as we know him today in the United States and in other countries is a relative newcomer. The general practitioner is some 200 years old in this country, and about 100 years in Great Britain (*5*, *6*). The 19th century also saw the appearance of the general practitioner in France and Germany out of the fusion and elimination of several categories of practitioners. The modern specialist made his appearance around the fifties and sixties of the last century (*7*). Most characteristic of these practitioners from a social and economic viewpoint was that they were individual, small entrepreneurs, members of the middle class. As small entrepreneurs, they shared the socioeconomic attitudes and views of other middle-class groups. (Social and economic class as used in this discussion refers to configurations of behavior—occupational or productive activity, life styles, patterns of consumption, political and other belief systems—which exhibit a sufficient degree of consistency to make it possible to distinguish from one another groups in the social organization of a community. This does not imply that social and economic classes are homogeneous layers in a social structure. This is particularly so in the case of the middle class. Initially, in the medieval urban communities a somewhat cohesive social and functional group of merchants, tradesmen, and artisans, it has undergone changes in the course of history. New alignments and tensions between various intermediate economic or social groups have led to such essentially historical designations as the older and the newer middle classes. Among the various component elements of the middle class may be counted middle-size entrepreneurs in industry and trade, small shopkeepers, professionals such as the physician, lawyer, and teacher, and officials and salaried employees. According to the Oxford English Dictionary, the term "middle class" was employed in 1812, and John Wade, in 1833, refers to the "middle classes" (*8–13*).)

The fact that these practitioners were small entrepreneurs and shared the socioeconomic attitudes and views of other middle-class groups has been most clearly evident in the United States. The social philosophy of liberalism, combining the ideas of Adam Smith and Thomas Jefferson, provided the ideological framework for these attitudes. The task of government was to provide the fundamental security needed for community life, especially the protection of property, but government action was to be kept to a minimum. There was little or no need for a strong central authority, because local government could handle most community problems. As far as possible, it was felt, the individual should be free of regulation and given full scope for individual initiative. While certain undertakings required joint action within the community, each man was held to be entitled to carve out for himself the largest possible stake.

The American physician of the 19th century shared these views with his neighbors and acted accordingly. Each man was sufficient unto himself, except as he adhered to rules of professional behavior established by his colleagues. Competition was accepted as natural and was quite brisk. According to William J. Mayo: "Competitive medicine was the response of the individual physician to his training and environment. It fostered self-sufficiency and jealousy" (*14*). The physician ran his practice from his office, with little recourse to the hospital or to complicated equipment.

Social Change and Group Practice

Since the end of the 19th century, and to an increasing degree following the First World War, this self-sufficiency has been undermined. The physician and his practice have become inextricably intermeshed with the increasingly complex social organization which exists for the provision of medical care. In this process the hospital has come to occupy a central position. (This association of the physician, particularly the general practitioner, with the hospital occurred to a much greater degree in the United States than in Great Britain or on the continent. For all practical purposes, the general physician has not been a member of the

hospital staff in Britain or in countries such as Germany, Austria, or France. The movement to exclude the general practitioner from American hospitals is a recent development and has led to various countermeasures.)

The practitioner must depend on expensive equipment, as well as on specialists and technicians for diagnosis and treatment. The situation was strikingly illustrated by Dochez in a comparative picture of the complex changes wrought in medical practice over three decades (*15*). He contrasted the histories of two patients with similar types of heart disease; one was recorded in 1908, the other at the same hospital in 1938. The total written record of the first patient occupies 2½ pages and the observations represent the combined efforts of 2 physicians, the attending and the house officer, and of 1 specialist, the pathologist-bacteriologist. The record of the second patient, who was still in the hospital when Dochez made this comparison, comprised 29 pages and represented the combined observations of 3 visiting physicians, 2 residents, 3 house officers, 10 specialists, and 14 technicians, a total of 32 individuals.

Today, the medical practitioner must have some hospital connection, both for his patients and for himself (*16–19*). The fledgling physician is no longer apprenticed to another physician, but to a bureaucratic institution, the hospital, where he serves as intern and resident. Furthermore, he must depend on relations with other medical men to get started in practice and to keep a clientele. Throughout his career, hospital appointments are crucial to his practice and to his advance in some medical hierarchy. To a considerable degree, the referral mechanism is controlled by informal cliques in hospitals. At the same time there has been an increase in the number of ancillary occupations filled by persons on a salaried basis. One major consequence of this system has been to narrow the area of practice (the market) of the general physician, and to imply, often correctly, that he is not competent to handle a number of types of illness.

These trends and facts underlie the behavior of physicians in relation to various forms of prepaid and organized medical care: Blue Cross, Blue Shield, prepayment group practice plans, hospitals, union health plans and centers, and above all, government action in the health field. Viewed and interpreted sociologically, the behavior of a large part of the medical profession represents the reaction of a segment of the older middle class to the process which is compelling it to come to terms with modern industrialized society. To use an analogy, one may say that medicine is experiencing its Industrial Revolution, and that the medical practitioner is being brought into the "factory" (the hospital and the whole complex organization for the provision of medical care), where he is being subjected, on a privileged basis, to the requisite "labor discipline."

Competition and Survival

The entire profession and its field of action are undergoing change, but different kinds of practitioners face varying situations. The general physician endeavors to keep hospitals, specialists, and other organizations and individuals concerned with medical care from competing with him and limiting the area of his activity in ways which he considers unfair. This aim is implicit in the establishment of the Academy of General Practice, of general-practice departments in hospitals, in the idea of an American Board of General Practice, and in the opposition to review and control of the quality of medical care offered by prepayment organizations and welfare funds. The general situation also affects the specialist, who wishes to maintain the status quo so that his privileged position will not be altered. He endeavors to render ineffective any threatened competition. Considerations of this kind, whether overt or covert, are involved in the insistence on free choice of physician, on fee-for-service practice, and in all the other battle cries that have echoed on the medical care battlefields for more than four decades.

But while the self-sufficiency of the physician as entrepreneur is undermined by the march of science, technology, and social organization, the ideology of competition and rugged individualism still remains the uncompromising official creed. According to this ideology, the solitary individual, endowed with personal merit, makes his way against others in the open market. The effort involved in this competitive process provides, it is believed, the condition

for the development of self-reliance and the achievement of success. Under the impact of expanding industrialism in the United States, the medical profession joined other middle-class groups in accepting this philosophy and applying it to questions of public health and medical care. Theoretical justification for refusing to use tax funds for the expansion of public health work, or for the provision of medical care and other aid to the poor, was sought in the Darwinian theory of evolution. Disease was a special case of the struggle for existence, and one of the means by which the fittest survived (*20*).

Today, the principle of State intervention and control in health matters is generally admitted, although variations may exist in practice due to the greater or lesser efficiency of the intervention and in the greater or lesser frankness with which the role of the State is admitted. Its emergence has come from the interaction of important economic and social trends. For one thing, during the period from the end of the 19th century to the present, the trend of economic organization has been the continuous and progressive replacement of smaller units by larger ones. The further this process advanced the more untenable has become the conception of noninterference by the State. But while other elements of the middle class, for example, the small businessman, sought protection against the large producer and competitor through government action, the medical profession was able to continue relatively untouched by change in the privileged sanctuary of private practice. And for the most part its ideology has remained intact.

The *Chicago Medical Journal and Examiner* wrote in 1879: "It is frequently stated that the poor should be protected by the government against the causes of disease which are said to infest the habitation of the lower classes. . . . It is the lazy people and their sentimental friends who are always calling for government aid. If now you undertake to protect this fraction of the community, you have to protect it against the consequences of idleness, luxury, intemperance and vice—thus interfering with the operation of the wholesome monitory laws of nature; and you do it at the expense of the meritorious classes of society. Having accustomed such worthless people to rely upon government for protection against smallpox, and scarlet fever, and syphilis, and diphtheria, and sewer-gas, and scabies, it will not need the passage of many generations before they will demand protection by the government against the cold and hunger and nakedness for which they should themselves make provision" (*21*).

The same gentle spirit still pervaded the editorial views of the *New York State Journal of Medicine* in 1949 (*22*, *23*): "Any experienced general practitioner will agree that what keeps the great majority of people well is the fact that they can't afford to be ill. That is a harsh, stern dictum and we readily admit that under it a certain number of cases of early tuberculosis and cancer, for example, may go undetected. Is it not better that a few such should perish rather than that the majority of the population should be encouraged on every occasion to run snivelling to the doctor? That in order to get their money's worth they should be sick at every available opportunity? They will find out in time that the services they think they get for nothing—but which the whole people of the United States would pay for—are also worth nothing."

Heresies

From the last decades of the 19th century to the present day, a variety of "heresies" in the financing and organization of medical care have been opposed with ideological weapons obtained from this philosophy. Dispensaries, free public clinics, contract medical schemes, and prepayment medical care plans have all aroused opposition and have been met with similar arguments. The abuse of medical charity agitated physicians and their organizations from the 1880's onward (*24*, *25*). Allegedly, free clinics for the poor were being used by others less deserving of charity, who would consequently be "pauperized." To the concern with free clinics and their effects was soon added the problem of contract schemes, and just before the First World War came the movement for national health insurance. These innovations were opposed on the ground that they subsidized the inefficient and the lazy, they destroyed the personal relation between physician and patient, they decreased professional com-

petence, they were unethical, and similar arguments which still ring familiar.

It is clear that not all physicians shared the official view. For example, in 1889, J. L. White proposed a prepayment plan by which physicians would contract to provide services, emphasizing preventive care, for families for an annual fee (*26*). The following year a prepaid medical care plan was actually initiated in Chicago by J. K. Crawford and Oscar DeWolf, but the Chicago Medical Society condemned the two physicians (*25b*). Later, a small group in the American Medical Association also favored compulsory health insurance, but they could do little in the face of the dominant opposing view (*27*). To a certain extent, such innovating individuals and groups have been favored by periods of rapid social change and reform. This was true during the first decade of the 20th century, the era of progressivism, and to a certain extent during the New Deal thirties.

Under the threat of a national system of health insurance, voluntary health insurance has developed and spread. At least in principle, the American Medical Association has accepted prepayment group practice. Furthermore, a large part of the medical profession, about one-third, today works wholly or in part for salaries (in hospitals, medical schools, for other physicians, government agencies, unions, and pharmaceutical companies).

Continuing Tradition

Nonetheless, the emphasis is still on individual responsibility for medical care, fee-for-service solo practice, and free choice of physician. And even though the medical practitioner may not wholly subscribe to the philosophy, policies, and practices of the professional groups that represent him or speak in his name, he cannot help but be bound by these rules, at least in some measure, whether or not he is aware of this.

In becoming a member of his profession, the medical practitioner undergoes a process of socialization, involving not only the acquisition of knowledge and skills, but even more significantly, perhaps, the acquisition of the values, attitudes, and behavior patterns that enter into and make up the physician's role. Even when the practitioner deviates from the dominant values, attitudes, and behaviors of his profession, he rarely breaks completely with them. In considerable measure, his relations with his patients may still be determined by these elements, even when he practices in a different setting, for instance, in a medical group. Numerous elements of his role will still be appropriate in this new setting; others, however, are either totally or partially dysfunctional. As a consequence, working in a group practice setting requires changes of attitude and behavior resulting from the acquisition of new goals, reference groups, and relations with colleagues, patients, and other involved persons and groups.

Some forms of change are socially approved. Physicians, for example, are expected to keep abreast of new developments in medicine and related fields so that medical practice can be carried on at the highest possible level. Even here, tradition may exert a restraining influence. Change in the provision of medical care is not generally sanctioned by the groups that set the rules for medical behavior; indeed, it has occurred against strong opposition. Unless there is some compelling reason, change is not easily or lightly undertaken in such a situation by any group of people. During the Second World War, a considerable number of younger physicians in military service were apparently interested in group practice upon returning to civilian life (*28*). As is well known, however, they did not flock into group practice. While a number of factors were involved in this development, it appears likely that many of these physicians simply took the traditional path because it was easier, coinciding as it did with several other developments, among them, economic prosperity, a rise in the standard of living, social disapproval of nonconformity, as well as legal barriers to prepayment group practice. (This is an interesting problem for social research.)

Here one may ask: Would group practice have increased more rapidly had these conditions not existed? Obviously, such a question is difficult, if not impossible, to answer. Group practice requires the investment of capital to begin with, and that it be available when needed. It may be that even if the physicians had wanted to organize group practice units,

adequate capital resources might not have been available. After all, the Health Insurance Plan started with loans from several foundations, and it is noteworthy that the only other group practice plan of comparable size (Kaiser Plan) started on an industrial base. Furthermore, are there any inherent limitations in group practice as an organizational form? The answer must be that we do not know.

Nonetheless, there are hints from investigations concerned with the sociology of bureaucratic organizations. Some of the problems brought about by the size of an organization have been studied. Tsouderos, for example, in examining 10 voluntary organizations, found that the introduction of more formal procedures and greater specialization of function, as organizations grow, tends to alienate a number of individuals (*29*). The emergence of a heterogeneous membership can also be an outgrowth of the increasing size of an organization. Such a development carries with it the probability that the members will have dissimilar views on various matters. This in turn can lead to a decrease of consensus (*30*). However, none of these studies has been concerned with medical care plans, and one may suggest that group practice could be a fruitful area for research.

Role Performance

By virtue of the process of socialization, the physician acquires a scale of values, a set of attitudes, and a way of thinking and acting which is distinctive in various respects. Some of these are traditional and represent the "conventional wisdom" (to borrow a term from J. K. Galbraith's book, The Affluent Society) of the medical profession. As part of this process, there develops a professional self-image, a definition of the physician's role, which enables him to carry out his obligations under a variety of circumstances. In some environments, the performance of this role is more visible than in others and consequently more easily available for control (*31*). The physician in his private office is subject chiefly to the controls of the professional values and norms, to his concept of himself as a professional person, and to what he considers good practice. These controls are buttressed in varying degree by sanctions both within and outside the profession, such as expulsion from a medical society or a malpractice action. Otherwise, the physician in his office is not very visible in performing his role, except to patients usually unequipped to pass sound judgment on his action in technical terms.

Some environments are so structured that the practitioner is under the continuing scrutiny of others who appraise the way in which he performs his functions. This is true of the hospital, with its requirements for records, arrangements for staff conferences, consultations, and other accepted responsibilities. What is true of the hospital can apply equally in a prepayment group practice plan or in a labor union health center. In such organizations, the practitioner's behavior not only is visible to his colleagues, but is or may be scrutinized by prepayment plan officials or welfare fund administrators. Furthermore, there may not be agreement on the standards by which performance is judged. In any event, what exists in these organizations is a mechanism for social control which makes him subject to pressures of various kinds. Where the limits of observability in the medical situation are to be drawn is not easily determined, but it should be obvious that physicians strongly imbued with an individualistic ideology will not easily accept the controls involved in more complex types of medical care organization. (The problem is not limited to the performance of physicians and others involved in the provision of medical care. Similar problems confront members of the teaching profession (*32*).)

This thesis is based on Robert Merton's concept of the role-set, that is, the "complement of role-relationships in which persons are involved by virtue of occupying a particular social status" (*32*). In the case of the physician and his status, this entails not only the role of a practitioner vis-a-vis a patient, but also an array of other roles relating him to his colleagues in a medical group, to nurses, laboratory technicians, health plan administrators, medical societies, and the like. The relationships physicians have with persons in each of these positions are by no means identical, and involve situations calling for differing attitudes

and behavior. Patients, for example, will differ from physicians in their expectations of the medical practitioner to whom they come for care. Furthermore, not all those in the particular role-set are involved in the same way or in the same degree, and it is important to know what various participants in a role-set bring to it.

Social Class and Therapy

Ideally, the role performance of the physician in relation to a patient centers in impartially serving the patient's health needs regardless of any liking or antipathy he may have for the particular individual. Like all ideals, however, it is only approximated in reality; and this is true in solo practice as well as group practice.

The practice of medicine is affected by the social class system. That the physician is a member of the middle class has already been pointed out, and whether or not he is aware of it, much that he does is influenced by the element of social class. A number of studies in the United States and in other countries highlight the significance of class considerations. Diagnostic and therapeutic decisions, for example, are influenced by the social distance between the practitioner and the patient. Some physicians are either intuitively aware of this factor or have learned by experience to take it into account. In many instances, however, there is no awareness of the distance separating physician from patient, and consequently no attempt is made to narrow this gap.

Aubrey Lewis has pointed out that the psychiatrist and his patient usually share the same subculture, and can therefore define the situation and the problem in a mutually acceptable manner (*33*). This point has been made more explicit by a number of empirical investigations, which show that patients with mental illness who most nearly approach the practitioner's social class are likely to receive psychotherapy rather than organic therapy or no treatment and are more likely to be considered hopeful from a therapeutic viewpoint (*34*, *35*). Williams has called attention to the need for taking into account the class premises of the patient. If this is not done in psychiatry, differences in the perception of problems and their solution may lead to incorrect diagnostic conclusions (*36*).

Class perceptions and values of the patient may likewise affect practitioner-patient relations. In Regionville, for example, Koos found that members of the lower class felt that physicians were not particularly interested in them as patients. He further reported "a lack of communication between the physician and his patient. Part of this lack was due, no doubt, to the fact that physician and patient too often represent differing subcultures, and 'speak different languages'" (*37–39*).

Such observations are not limited to the United States, but have been reported from other countries, such as England and France (*40*, *41*). Furthermore, members of the lower social class are less likely to use child health clinics, have their children immunized, or use medical care services when they are members of a prepayment plan. Differences of this kind are likely to be accompanied by differences in expectations concerning illness and therapy. Persons in lower income groups, especially families of unskilled workers, are subject to a number of limitations which affect their behavior with respect to preventive medicine and medical care. For one thing, the horizon of this group is severely limited by fear, ignorance, and misunderstanding, as well as by different types of reaction to life situations. This is true not only of health (*42*, *43*). There is some evidence to suggest that the unskilled English worker feels that his ability to influence the course of events is severely limited. Consequently, there is less stress upon the individual's responsibility (*44a*). Furthermore, actions are confined generally to the needs of the moment, and the future is allowed to take care of itself. Working class families also tend to be suspicious of authority, and the official health agency may personify this (*44b*, *45*).

Orientation to upward mobility may be another factor which affects the patient's reaction to medical care organization. For example, proponents of group practice feel that this way of providing medical care simultaneously meets the needs of both patient and physician (*46*). Behind this idea is the implied premise that patients, physicians, administrators, and

others will see the group practice in the same way. Yet the actual members, the patients, in a group practice plan are more likely than not to be a heterogeneous group—teachers, firemen, machinists, government workers, bus boys, and so on—with diverse expectations and attitudes in terms of past experience, educational background, ethnic origin, social class, and the like. In HIP for instance, it was assumed on rational grounds that it would be more advantageous to all concerned to provide medical care through medical group centers. Yet, the only concrete experience that many workers have had in receiving care from anything resembling such a center is in clinics and outpatient departments of hospitals, of health departments, and similar agencies. Such services still have a "charity" connotation, or at least a lower status association for many people. Experiences in such facilities explain also "why outpatients feel like outcasts" (*47*). For such people, to receive care in a physician's private office is a step upward, and any move to bring them into a situation such as prepayment group practice with medical care provided in a facility which can be related to the objectionable clinic will be resented. Naturally, this does not apply to all, but there are enough people to whom it does apply and who make themselves heard. One may suggest that this is one of the factors behind the dual choice arrangement now offered by the Kaiser Foundation Health Plan and by the Health Insurance Plan of Greater New York. In short, the definition of the situation by the patient cannot be assumed to coincide automatically with that of the physician or of the health plan administrator. They may even run counter to one another.

Conclusion

Like the public health and social welfare movements, the movement for prepaid medical care in the United States was originally conceived and implemented chiefly by middle-class people, even though intended to benefit members of a lower social class. Motives of social amelioration propelled to action the proponents of such schemes as prepayment group practice, who were acutely aware of the economics of medical care and the social consequences of lack of care. Furthermore, members of the middle class are future oriented, prepared to forego present satisfactions in order to achieve future goals (*48*). Great value is placed on health as a means to an end, and the use of rationally calculated means to reach such a goal. Small wonder, then, that financing and administration have been the major concerns of the movement for increased and improved medical care. This is clearly evident in the otherwise excellent volume, Readings in Medical Care. But just as the Sabbath is made for man, so medical care is financed and organized to provide service to people, who whether one likes it or not are not all alike and do not all share the same goals, values, and norms. The health education program of the Health Insurance Plan, for example, is based on a recognition of this premise (*49*, *50*).

Only recently, however, has there appeared an explicit awareness of the central relevance of social science for the provision of medical care. Patients, physicians, administrators, union leaders—all have certain value orientations, behavioral characteristics, class memberships which are important factors in determining how medical care programs operate and what their outcome will be. The closer to the habitual the more easily accepted. Group medical practice as an innovation depends for acceptance or rejection on how those involved in it perceive it. If these perceptions conflict with the individual's behavior and ideas derived from his class position, there is clearly a need for understanding and action. Certainly, this is an area for research and the implementation of the resulting knowledge.

This analysis has touched on a number of points and has endeavored to indicate a framework—historical and sociological—within which group medical practice must be seen, if its problems are to be understood. There is a full awareness on my part of the possibility and the need for even more intensive analysis of various points. However, as the objective of this analysis is solely to call attention to important dimensions of the medical care problem and to stimulate thought and action concerning the ways in which significant contributions might be made to improved medical care, there is plenty of opportunity to occupy the energy and ingenuity of others.

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Methodology Research Award

The deadline for nominations for the Eighth Kimble Methodology Research Award is June 1, 1959. The award, $1,000 and a silver plaque, is given annually in recognition of the application of scientific knowledge to the public health laboratory.

Candidates from the United States, its Territories, and Canada will be considered. They may be nominated for making a fundamental contribution which serves as a baseline for the development of diagnostic methods within the province of a public health laboratory or for the adaptation of a fundamental contribution which makes it useful in a diagnostic laboratory.

The Kimble award, established by the Kimble Glass Co. of Toledo, Ohio, and sponsored by the Conference of State and Provincial Public Health Laboratory Directors, will be presented at the annual meeting of the conference in Atlantic City, N.J., in October 1959.

The rules governing nominations can be obtained by writing to Dr. E. T. Bynoe, chairman, nominating committee, Kimble Award, Laboratory of Hygiene, Department of National Health and Welfare, Ottawa, Ontario, Canada.