Public Health Then and Now

Contract or Lodge Practice and its Influence On Medical Attitudes to Health Insurance

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Resistance by a large number of American physicians to prepaid medical care, particularly under government auspices, has deep roots that can be traced back to the turn of the century. This position had developed initially in reaction to contract practice, a term designating an arrangement where a physician agreed to provide medical service to groups of patients such as members of benevolent organizations, fraternal lodges, or employees of industrial companies for a fixed fee per annum. This practice apparently grew out of an earlier retainer arrangement whereby a physician accepted an annual fixed sum of money for services rendered to an individual or to a family, without regard to the amount of service. Describing the situation of the profession in the District of Columbia in the years immediately preceding the Civil War, Samuel C. Busey, a leading Washington practitioner, noted that such a system had long been in vogue among physicians practicing in Georgetown.[1] Nor was the system limited to a particular section of the United States. In 1869, on a motion by J. S. Moore, a Mississippi physician, the American Medical Association condemned the contract system as "contrary to medical ethics," and resolved "that all contract physicians, as well as those guilty of bidding for practice at less rates than those established by a majority of regular graduates of the same locality, be classed as irregular practitioners."[2] That such condemnation had little or no effect is indicated by the denunciation of contract practice in 1877 by the California state medical society and the Los Angeles county society. Fourteen years later in 1891, the contract system was again attacked by the state society and its members were urged to sign an agreement not to practice in this way. The failure of this approach is evident from a proposal in 1897 that the county society expel members practicing on a contract basis, but this attempt lacked support and no action was taken.[3]

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Increasingly, however, following the turn of the century, the problem of contract practice aroused the concern of practitioners. The situation was particularly acute in urban areas where contract practice was most prominent. As Robert A. Allen, a physician, observed in 1914, "There is scarcely a city in the country in which medical societies have not issued edicts against members who accept contracts for lodge practice."[4] As S. S. Goldwater, health commissioner of New York City, noted the following year, "In many localities medical care by lodge doctors is the chosen or established method of dealing with sickness among the relatively poor." To indicate the prominent role of this form of practice, he reported that in North Adams, Massachusetts, a city "with a population of 22,000, 8,000 persons are in the care of lodge physicians to whom the members pay an annual stipend for medical care."[5]

A more detailed picture of contract practice in Rhode Island and in its largest urban community, Providence, was drawn in 1909 by George S. Mathews, a physician of that city, in a report presented to the American Academy of Medicine as part of a panel discussion of the problem.[6] In considering the distribution of contract practice in Rhode Island, he emphasized that the "lodge doctor" was almost unknown in the rural areas and small towns, and even in cities where such practice was common it was found only in some sections. However, in these areas Mathews reported "it is almost as rampant as it is in the East Side of New York City." Contract practice was common in communities and sections of cities inhabited by workers and their families, many of them immigrants or the children of immigrants. Overwhelmingly, they belonged to the working poor who were or could become medically indigent.[7]

According to Mathews, contract practice involved three types of organizations: lodges and fraternal groups; factory and shop organizations; and private clubs generally organized by physicians, which were most numerous in several immigrant neighborhoods. As in other parts of the United States, there were many lodges and fraternal organizations with numerous branches in Rhode Island, with some kind of

medical care among benefits available to members. Mathews reported that:

"The English, Irish, Scotch, Germans, French-Canadians, and Jews have clubs employing the contract doctor. The Manchester Unity, Foresters, Sons of St. George, Eagles, Owls and others are in this number. The rates for the physician vary from $1 to $2.50 per member per annum. In Providence one of these lodges numbers about 1,200 members. This lodge pays its doctor $2.00, but this price includes medical attendance on the entire family. In this instance the physician's clientele must be between 4,000 and 5,000. Surgery and obstetrics are not included.

"Among the Jewish people of Providence it is estimated that one-third have contract doctors. In the Olneyville and Mount Pleasant districts it is estimated that 50 per cent of the wage-earning men are members of lodges employing contract doctors. In the populous Pawtucket Valley mill towns at least six medical men . . . are engaged in lodge practice."[8]

A number of factories and shops also had organizations of this kind, which included men and women, but were limited to employees. Mathews describes two such "clubs" in one factory, the larger having a membership of about 700, the smaller 400. The larger club paid its physician $2.25 a year per member, inclusive of medicines. For similar services the other club paid $2.00 per person annually. Apparently it was more exclusive since its membership was limited to workers who earned at least $12.00 and as high as $30 per week. The average weekly wage in the larger club was from $10 to $15 per week. In the factory where the members were employed their requests for office or house calls were posted on a slate, and the practitioners hired by the clubs called daily to note who wanted to see them. The number of requests varied, but in the larger club there were between 15 and 35 office visits and two to three house calls a day.

The third type of contract practice comprised the groups organized by medical practitioners. They were small but numerous among the foreign born in some sections. Ten or a dozen families might be brought together, with each family paying the physician $3 to $5. Under this arrangement medical attendance was provided for all members of the family, but surgery, obstetrics, and medicaments were excluded. The largest of these clubs solicited members in factories and stores. For $1.00 a year, medical and minor surgical conditions were treated at the office. Home visits were not included, and a small fee was charged for medicines.

Mathews' comment that contract practice was exceedingly widespread on New York's lower East Side is supported by other sources. Newly arrived immigrants crowded together in separate neighborhoods in the large cities where they soon organized institutions within which they could establish a sense of community and which would provide various forms of assistance when needed. Jewish immigrants in New York City, for example, formed benevolent associations, progressive societies or other groups. Such a lodge, or to use the generic Yiddish term *landsmanshaft*, was initially made up of persons from the same town or region in the country from which they had emigrated. The vast majority of these lodges were formed during the first decade of the century at the height of the great migration. Though estimates of their number vary from about 3,000 to almost double that figure, the lower estimate is probably closer to reality.[9] In 1910, Morris J. Clurman, a physician practicing on the East Side, reported that "there are in existence downtown somewhere between 1,500 and 2,000 lodges, societies, and benevolent associations founded mainly by the poorer class of workingmen for a double purpose; namely social intercourse or mutual aid or benevolence."[10]

Among the benefits provided by the lodges to their members was attendance by a physician when illness occurred. As Clurman put it, "An iron-bound practice or custom has arisen for each society to elect some physician to take care of the health of the society members—for a consideration." The society paid the physician on a capitation basis. In New York in 1910 the average rate of remuneration was $1.00 per annum for an unmarried member and $3.00 a year for a married member and his family, but not infrequently the retainer was smaller. What this meant in practice has been graphically described by Samuel Silverberg, who had been a lodge doctor in this period. He recalled in 1972 that the "society would pay me a certain amount for coverage for a certain number of patients—fifty cents for a single member every three months, seventy-five cents or a dollar for a family. Every member had a right to come to my office and ask me to call at his house. I took the job because in that way I was sure of being able to pay the rent for my office. On my own I took in very little . . . I delivered babies in the house and would get a practical nurse to follow up for a week or so. The society member paid extra for the delivery of babies, something like ten or fifteen dollars, as I remember.

"The society member would recommend the doctor to his friends, and in that way you could build up a practice. But it was hard, lots of running up and down tenement stairs. When I moved my office to the Grand Concourse, I gave up the society."[11]

There were advantages as well as disadvantages in such schemes for both practitioner and patient. Physicians undertook lodge practice as a means of obtaining a reputation and a clientele. The lodge doctor found that at the bedside he came in contact with a large group of patients who otherwise would not have called upon his services. After establishing a reputation as a busy practitioner, in part due to the recommendations of numerous families whom he had attended as a lodge doctor, and in part as a result of the normal growth of practice, the physician tended to disengage himself from lodge practice.

For needy young practitioners, however, as well as for older physicians with meager earnings, a position as a lodge doctor meant a relatively assured minimum income. As a result, competition for such posts was keen. Since the members of the lodge (or society) elected the physician who would look after their health needs, candidates frequently electioneered for votes. At an election where there were several candidates, it was not unusual for each one to come prepared with printed ballots bearing his name for distribution among lodge members. Some used more devious means to obtain the desired position. Under such circumstances one is not surprised to find a considerable degree of ambivalence in attitude and behavior on both sides of the physician-patient

relationship. The situation is well summed up by Silverberg. "Some doctors were devoted," he observed, "many not. Some patients took advantage of the system and it wasn't always very pleasant. Most society members treated their doctor with respect, but some said, 'A society doctor? What can he know?' For more serious illnesses, they'd go to another doctor."[12] In short, how competent can a physician be who has to offer his skills as hucksters dispose of their wares?

This attitude had its counterpart in the feeling of many physicians that lodge members, for the most part workers, were hardly the best judges of the professional merits of a medical practitioner. Patient behavior in numerous instances tended to reinforce this view. The physician was obligated to see professionally as many patients as requested his services. Sometimes patients called for apparently trivial reasons, arousing the resentment of the physician who felt his time was being wasted. Practitioners who served more than one lodge, in some instances as many as seven or eight, probably saw 30 or more lodge patients in the office or at home in the course of an average day. At the same time, these physicians endeavored to establish or to maintain a practice devoid of the demands and uncertainties of lodge doctoring. Under these conditions it was virtually inevitable that the quality of care would be uneven, and in numerous instances poor. Superficial and cursory examination was not unusual, and more often than not therapy was directed toward symptomatic relief.

But there were also competent and conscientious physicians whose practice was not slipshod, who did not make snap diagnoses, who were painstaking in the care of their patients and treated them to the best of their ability. Yet even the best lodge doctors had definite limitations. They were general practitioners who worked individually, equipped with the knowledge and skills acquired through education and experience.[13] As long as medical practice was relatively simple, a diligent physician could care for lodge patients in a reasonably satisfactory manner. For lodge members, the provision of sickness benefits inclusive of medical care offered some protection against the burden of financial loss through illness, involving not only the cost of medical treatment but also the loss of earnings. Furthermore, without a doctor available, a considerable number of lodge members would probably have consulted a pharmacist and received some patent medicine, or used traditional home remedies, rather than incur the expense of a visit to a physician and the filling of his prescription. Very likely, some lodge members used all those resources, as well as free dispensaries.

Contract practice had developed out of the need to provide medical care for groups whose social and economic circumstances made it difficult, if not impossible, to do so individually. For this reason, a number of physicians urged the acceptance of contract practice by the medical profession, subject to the establishment of conditions which would be equitable for both patients and practitioners. In 1889, a program for prepaid medical care on a contract basis was proposed to the Illinois State Medical Society.[14] Families would be urged to contract for annual medical care with fees to be paid quarterly or monthly. The authors of the plan argued that physicians had to take account of the impact on medical practice of the scientific and social changes that were taking place and would continue. In view of the increasing significance of preventive medicine, its application in medical practice would be facilitated by the proposed arrangement.

In 1890, two Chicago physicians, J. K. Crawford and Oscar De Wolf, the latter a former health commissioner, started a prepaid program called the Mutual Medical Aid Association of Chicago. Its objective was to "secure to those of limited means prompt and efficient medical and surgical treatment in cases of sickness of accident, by a corps of competent physicians and surgeons, at nominal cost." The latter phrase was somewhat exaggerated since the dues paid by members of the association ranged from $12 per annum for a single person to $20 per annum for a family of five or more. Membership dues, paid quarterly, covered all professional services except obstetrics, which cost an additional $10.00. Salaried physicians employed by the association provided medical care. Although the organizers of the plan insisted that it was intended to provide health protection for workers in factories and plants, and that it was founded on a well-established insurance principle, the Chicago Medical Society condemned their activities.[15]

Yet the real problem which Crawford and De Wolf tried to solve did not disappear. In Chicago, as elsewhere in the United States, there was a growing feeling that some form of properly organized contract practice would be preferable to the existing situation. As a committee of the Chicago Medical Society, appointed to study contract practice, reported in 1907, "many of the men working under these various contracts are desirous of improving the conditions of things, that they are not wanton violators of the ethical codes and that they are willing to cooperate in any amicable solution of the question."[16] Furthermore, recognition that the economic necessities of many patients and physicians made some form of prepaid medical care inevitable became increasingly prevalent by the second decade of the present century. Indeed, by 1913, the Judicial Council of the American Medical Association concluded that "Lodge practice under certain circumstances is one of health insurance that must be accepted and controlled, not condemned and shunned." By 1914, Robert A. Allen, surgeon for the A. C. White Lumber Company of Idaho, said it was not surprising that "workingmen who have learned to organize themselves in trade unions should also unite for mutual protection against accident and illness. It is not surprising that American workingmen should be following in the footsteps of their European confrères with their Friendly Societies and their Krankenkassen." Pointing to the social legislation of various European countries, particularly Great Britain and Germany, Allen noted that there were "many indications that we are rapidly approaching the time when similar government insurance will be adopted in the United States." It was only a question of time and Americans would also have "state insurance against sickness, nonemployment and old age."[17] The following year S. S. Goldwater saw the United States moving toward sickness insurance, and pointed out that teamwork was essential for good medical care. This goal could be achieved through hospital clinics and dispensaries for ambulatory patients where

"the medical work will no longer be charitable work, but part of a scheme of social insurance," in which "adequate compensation will have to be provided for the doctors."[18]

The same year, Stephen A. Welch in his presidential address to the Rhode Island Medical Society confronted this prospect and raised a number of specific questions that were to be of considerable future significance. If a prepayment scheme (or cooperative practice as he termed it) were instituted, who would be included and what would these individuals pay? How many persons should be assigned to a given contract physician? What is the proper remuneration for a practitioner caring for a given number of people? Should the medical society negotiate an agreement on what the fees shall be, whether with the state or with an insurance company, or whoever will pay the practitioners providing service? Shall the medical society provide a list of suitable or approved physicians for the persons covered by the scheme, and how would they be selected? Welch emphasized the need for the organized profession to study the problem of sickness insurance in terms of such questions, otherwise, "it may pass into practice without such reasonable regulations as physicians are best qualified to suggest."[19]

Others beside Welch had also recognized the complexity of the problem and identified major issues. Commenting on the discussion of contract practice at the annual meeting of the American Academy of Medicine on June 7, 1909, Charles McIntire, editor of the Academy's *Bulletin*, listed among the many factors at issue, "The principle by which the physician should charge for his services; is the usual way of the family physician, the only way, or in fact the best way?" Equally salient was the question of what is adequate compensation for professional services, particularly since a major objection to contract practice was the inadequate remuneration of the physician, especially by benevolent societies, fraternal orders, lodges, clubs and the like. To deal with these issues as well as the problem of the medically indigent, which McIntire recognized, he asserted that "a plan by which the wage earner may receive proper medical attention and the physician be properly paid for his services" could be achieved only on a cooperative basis. To obtain a secure foundation for such an enterprise, he insisted that "facts must be known, and as the life insurance actuary prepares his tables of the expectancy of life, so must tables be prepared to determine the expectancy of disease. Upon these tables the fee to be paid to the lodge or society must be determined. In the second place the proper fee to recompense physicians for such services should be determined." As a standard, McIntire suggested that a sum equal to the average salary of physicians who had salaried positions in medical schools, or who were health officers or researchers in hospital laboratories, be paid for an equal period of time in a lodge contract. Another question raised by McIntire concerned the average number of families to be cared for by a physician so that proper attention could be given to each person who might be ill, without making excessive demands on the practitioner so that he could have time for study and recreation. Finally, McIntire urged that the contracting organization, lodge, or society, "should charge its members a fee sufficiently large to pay for the entire time of as many physicians as may be necessary to give each one a proper clientelle, and pay a fitting salary. Under such conditions, no odium could attach to Contract Practice."[20]

Five years later, in 1914, Albert T. Lytle, a physician of Buffalo, New York, addressed himself to the same questions, particularly to the problem of the physician's remuneration. Lytle attributed this problem to the chaotic state of the medical market resulting from changes in the organization of medical practice. "The rapid development of surgery," he said, "the startling growth of the specialties, the immense and expensive scientific equipment required, the great cost of a medical education, the pharmacist and the nurse, all have had a disastrous influence upon the former well-balanced remuneration of the physician."[21] To correct the situation, Lytle proposed specifications to be taken by state and county medical societies. One was the creation of a committee on medical economics to study and to make recommendations on all economic questions of concern to practitioners. Accepting the inevitability of contract (i.e. prepayment) practice, Lytle urged that as one of its major priorities, such a committee ought to establish the "service-value" or cost of specific services rendered by physicians. These determinations could then be used in negotiations with insurance companies, government agencies, or lodges, and would make it possible to set "minimum medical remuneration, or selling prices." To insure compliance with these standards by all physicians, Lytle proposed unionization of the profession by bringing "all eligible practitioners into the medical societies" which would represent them vis-a-vis other groups. Finally, to put these proposals into effect, to work out the problems of medical service costs and remuneration, and eventually to obtain valuable statistical data, he suggested the organization of a Mutual Health and Accident Insurance Society, incorporated, financed, and managed by physicians. The policies written by the Society would not provide for cash indemnity in case of illness, but would "furnish medical and surgical services and treatment, medicines, dressing, hospital accommodations and nursing attention during the period of a disability occurring during the life of the policy. The physicians and surgeons rendering such service should be stockholders or members of the association and they should receive from the association fees according to a proper schedule."[22] To minimize fraud, a few high-salaried full-time physicians of established competence should be appointed as inspectors or supervisors. Based on a population of 500,000 served by 500 physicians, Lytle estimated that an annual premium of $10.00 would produce enough income to cover costs and to provide for a sinking fund and dividends. Since the Society would be a nonprofit organization, any dividends would be used as far as possible to improve the quality of care and to reduce costs while providing the physicians with a secure and self-respecting living.

As revealed by the discussions of contract practice, the decades immediately before and after the turn of the century were a period of ferment during which alternative methods of financing and providing medical service were considered by the medical profession. Embedded in these discussions are premises that have remained central to positions taken since then by the majority of the medical profession on ques-

tions of health policy and medical economics. According to these premises, the needs and the welfare of patient and physician coincided. Since the economic security of the profession is essential to any health program, medical activities that do not assure the economic position of the private practitioner are fundamentally unsound. Consequently, society through its various agencies must not compete with the practicing physician in any way that would impair the structure of individual medical care and the economic status of the practitioner. As representative agencies of the profession concerned with public benefit, medical societies should determine whether contract or prepayment arrangement for medical care is in the best interests of the patient and the physician. Logically, therefore, any plan not approved by a medical society would be contrary to the public welfare.

Medical society control of health activities, the central point of this ideology, clearly reflects the desire of physicians, particularly general practitioners, to maintain a medical market based on individual fee-for-service practice, and to prevent various institutions and agencies from encroaching on the domain of medical practice and competing with the individual practitioner. This position is understandable if seen from the point of view of a practitioner who felt exploited and increasingly threatened economically by health departments, workers' compensation and industrial medicine, hospitals, free and pay clinics, and last, but ultimately not least, compulsory health insurance. It was from this position that the majority of the profession confronted proposals for compulsory sickness insurance first proposed in 1915, as well as other alternative ways of financing, organizing and delivering health care thereafter.

REFERENCES

1. Busey, S. C. Personal Reminiscences and Recollections of Forty-Six Years Membership in the Medical Society of the District of Columbia, and Residence in this City . . . Washington, DC, 1895.
2. Transactions of the American Medical Association 20:41, 1869. It should be noted that in the South it was customary to hire a practitioner on an annual basis to provide medical care on a large plantation for the family and the slaves. After the Civil War, physicians engaged in contract practice with benevolent societies and similar groups. See Duffy, J. History of Medicine in Louisiana, 2 vols., Baton Rouge, Louisiana State University Press, 1958–1962, vol. 2, pp. 100–101, 339–402; Waring, J. I. A History of Medicine in South Carolina 1825–1900, Columbia, S. Car., South Carolina Medical Association, 1967, pp. 118, 329.
3. Harris, H. California's Medical Story, San Francisco, J. W. Stacey, 1932, p. 263.
4. Cited in Albert T. Lytle: Contract Medical Practice. An Economic Study, New York State Journal of Medicine 15:103–108, 1915 (p. 106).
5. Goldwater, S. S. Dispensaries: A Growing Factor in Curative and Preventive Medicine, Boston Surg. Med. Journ. 172:613–617, 1915 (p. 614).
6. Mathews, G. S. Contract Practice in Rhode Island, Bulletin of the American Academy of Medicine 10:599–606, 1909. In addition to Mathews, the panelists included A. L. Benedict (Buffalo), Charles S. Sheldon (Madison, WI), H. T. Partree (Eatontown, NJ), A. Ravagli (Cincinnati) and Woods Hutchison (New York), all physicians, and John C. McManemin, past president of a lodge, the Fraternal Order of Eagles. The entire symposium appeared in the Bulletin with discussion of the papers on pp. 580–640.
7. Mathews refers specifically to the towns of Pawtucket, Central Falls, Woonsocket and Lonsdale and to the working class sections of Providence (Olneyville, Mount Pleasant, North End and South Providence).
8. Mathews, op. cit., p. 601.
9. Howe, I. World of Our Fathers, New York: Harcourt, Brace and Jovanovich, 1976, pp. 184–190.
10. Clurman, M. J. The Lodge Practice Evil of the Lower East Side, Medical Record 78:717–719, 1910 (Op. 717).
11. Howe, op. cit., p. 188.
12. Ibid., p. 188.
13. Goldwater, op. cit., p. 614.
14. White, J. L. Hygiene and Doctors' Fees, Transactions, Illinois State Medical Society, 1889, pp. 382–393; Thomas N. Bonner: Medicine in Chicago, 1850–1950. A Chapter in the Social and Scientific Development of a City, Madison, Wis., American History Research Center, 1957, p. 217.
15. Bonner, op. cit., p. 217.
16. Ibid., p. 218.
17. Allen, R. A. State Insurance Against Sickness, JAMA, June, 1913.
18. Goldwater, op. cit., p. 616.
19. Welch, op. cit. (footnote 1), p. 200.
20. McIntire, C. From the Field, Bulletin, American Academy of Medicine 10:652–654, 1909 (see p. 654).
21. Lytle, A. F. Contract Medical Practice—An Economic Study N.Y. State Medical J. 15:103–108, 1915 (p. 106).
22. Ibid., p. 108.

The Epidemiologist's Task

The epidemiologist has to deal with biological phenomena in all their natural complexity. He must try to recognize the relationships most common in certain specified ecological situations and to derive from this knowledge the methods of control having the best statistical chance of being useful in each particular situation.

René Dubos: Mirage of Health, Garden City, New York: Anchor Books, 1961, p.106.