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The Development of Multispecialty Group Practice at Henry Ford Hospital Through the Years

Address to the Detroit Academy of Medicine*

Bruce W. Steinhauer, MD†

The history of Henry Ford Hospital demonstrates the development of multispecialty group practice in a hospital setting. Analysis of our institution provides some insight into the problems and prospects of such large group practices. During my personal history of 20 years here, I believe that I lived rather than understood the organization until I was given the responsibility to replicate our ethos in another setting, the Fairlane Center. Moreover, I recently participated in a change in our governance structure, which moved us away from the traditional university style and more toward a group practice type of governance.

Although I would like to suggest that the idea of group practice was the guiding star from the beginning of Henry Ford Hospital, apparently it was not. Other major group practices founded at about the same time were outgrowths of the private practices of charismatic surgeons like Dr. Lahey, the Mayo brothers, or Dr. Oschner. Those practices were not hospital based and, in fact, Mayo Clinic does not own a hospital to this day. The apostle for hospital-based group practice was Dr. Cabot at the Massachusetts General Hospital, although that organization was almost totally unresponsive to the idea until recent decades.

The link between the group practice concept and Henry Ford Hospital apparently originated from several directions. Not the least of these was a conversation between Dr. Wil Mayo and Henry Ford in which Dr. Mayo extolled the advantages of salaried physicians for blending science and clinical practice. The point that seemingly did not occur to either of them was the important distinction between the doctor as the employer, Dr. Mayo’s idea, and the hospital as the employer, which was the vision of Henry Ford.

Henry Ford did not originate the idea for the Henry Ford Hospital. The result was the purchase of a tract of land, and ground was broken for the new hospital in April, 1912 (Fig 1). A list of staff members tentatively appointed included the name of Dr Frank Sladen (Fig 2) who had been brought from Baltimore where he had finished his medical residency at Johns Hopkins. The chairman of the Board of Trustees of the Detroit General Hospital was Henry Ford.

Two years later, the four buildings that had been begun were still not finished, and the Board of Trustees was discouraged. Serious consideration was given to making the new hospital a branch of Harper Hospital or turning the project over to the City of Detroit. At this point, Henry Ford agreed to pay off all the contributors if he could terminate all existing contracts and build and run the hospital according to his own ideas. His offer was promptly accepted, and under new management, the Henry Ford Hospital opened for patients on October 1, 1915.

Dr. Sladen wanted to merge practice with science. He apparently never gave much thought to the idea of group practice, which, in fact, was contrary to his temperament. For example, he retained the distinguished rheumatologist, Dr. Dwight Ensign, as Chief Resident for ten years before elevating him to a senior staff position. That practice was not unusual in the Henry Ford Hospital of the teens and twenties.

Mr. Ford, on the other hand, pointed out that he was not building this hospital “to make any man great.” He was no doubt referring to the rupture of his longstanding relationship with Dr. Metcalfe, who, although he had operated on Mrs. Ford, never became part of the staff of Henry Ford Hospital.

Ironically, although Mr. Ford did not propose to make any man great, that is precisely what did happen. After Mr. Ford and Dr. Angus McLean could not agree about the chairmanship of surgery (Dr. McLean did not like the...
Ground breaking for Detroit General Hospital, April 11, 1912. Dr William F. Metcalf is holding the spade; to his left are Henry Ford and David C. Whitney. The unimproved road on the right is the present Bethune Avenue looking west.

Fig 2
Dr Frank I. Sladen (1882-1973), first Physician-in-Chief of Henry Ford Hospital.

Fig 3
Dr Roy D. McClure (1882-1951), first Surgeon-in-Chief of Henry Ford Hospital.
Multispecialty Group Practice at Henry Ford Hospital

salari ed idea), Dr Roy McClure (Fig 3), also with a Johns Hopkins background, became the first Chief of Surgery and the great figure of the first decades of Henry Ford Hospital. In the end, it was a surgeon who put it all together for Henry Ford Hospital just as had been the case at its sister clinics. A gifted, charismatic man, Dr McClure had a warm relationship with Henry Ford, had an enthusiastic following, and was a fine educator. His early years were marred by cancellation of a meeting by the Detroit Academy of Surgery at Henry Ford Hospital. Dr McClure had invited the Academy, which cancelled its acceptance because of the controversial organization of the Hospital. Dr McClure resigned from the Academy as a result, but five years later, in 1929, he had rejoined and afterwards became its president. As a public figure, his fame became so great that when he died Detroit papers ran a banner headline that simply stated, "Dr McClure is dead." No Henry Ford Hospital doctor before or since has won that kind of acclaim.

Another relevant historical note is the matter of care for the poor. In turn-of-the-century Detroit before the development of suburbs, the poor lived in greater proximity to the middle and upper classes, and to a greater extent than is now the case, the same physicians cared for patients in all economic brackets. All physicians charged for services based on a sliding fee structure that formally permitted the well-to-do to subsidize the care for the poor. Henry Ford, the quintessential rich man with interesting social ideas, disclaimed that system in favor of a fixed fee schedule. Therefore, the fixed fee system was instituted at Henry Ford Hospital, although organized medicine vigorously opposed it at the time. Ostensibly, the fixed fee schedule was seen as an attack on the poor, who at Henry Ford Hospital, got the same bill as everybody else. The fact that a great number of those bills were quietly written off was never revealed, reputedly because Henry Ford disdained charity.

Issues of governance, growth, and social and educational responsibilities are constant areas of concern for institutions like Henry Ford Hospital. Medical governance is a particularly vital subject. The way in which physicians interact with each other and with their management colleagues at places like Henry Ford Hospital may be a laboratory for the world at large. In a "worst outcome" scenario, as American medicine adopts more and more features of large corporations, both doctors and hospital administrators (MHA) may eventually work for corporations managed largely by financial specialists. Product people (I think of MDs and MHAs as both in that category) may soon find themselves in the second echelon, as they have in many other industries. Whether society or the concerned industries are better off when that happens is problematic. If that prospect seems remote, note that Humana and Hospital Corporation of America (both for-profit, health-related corporations) are in good financial health, and an enormous number of physicians now work for HMOs that are publically traded on the stock market. I believe that both product and financial specialists have a role in the top echelon of the medical industry.

Health care professionals must continue to penetrate the highest decision-making levels in health care, as has been the case at the not-for-profit institutions such as Henry Ford Hospital. At the Cleveland, Mayo, Loevalce and Lahey Clinics, physicians were originally salaried and employed by physician-led clinics that had an oligarchical governance structure. In more recent years, professional staff members have played an increasing role in governance. At Henry Ford Hospital, doctors to this day work for a not-for-profit hospital, although the organization and mission are similar in many ways to these other large clinics.

Originally, our hospital organization was quite simple. Mr Ford initially assigned a trusted associate, Mr Liebold, to drive the project, and subsequently, operations were managed by a triumvirate: Dr Sladen, Dr McClure, and Mr I.R. Peters. Generally speaking, everybody else worked for them, and although it was not always harmonious, this arrangement was simple. Rightly or wrongly, all of them saw themselves as reporting to Mr Ford. Decisions did get made, although I understand that a physician who wanted a raise had difficulty getting an affirmative decision within that trinitarian system.

With the passing of Dr McClure and Mr Peters, and Dr Sladen's relinquishing his chairmanship, the benevolent autocracy continued through the 1950s and early 1960s under the leadership of Dr Robin Buerki, the physician manager who reported to a not-for-profit board of trustees. But a few years after Dr Buerki completed his tenure, department chairmen organized what, by retrospect, can be regarded as a revolution. The result was that a nonphysician Chief Executive Officer (CEO) was given responsibility for managing the institution with increased responsibilities for all departmental chairmen. Eventually the chairmen organized into a Council that shared responsibility with the CEO. Both before and since, the number of chairmen proliferated in a manner that did not occur at the Cleveland and Mayo Clinics but is more characteristic of a university medical school.

For example, Orthopaedics and later Urology left the Department of Surgery (where they still remain at the Cleveland Clinic). Neurology, Neurosurgery and Psychiatry, after various combinations, eventually all had chairmen, as did Radiotherapy when it separated from Radiology. Although special powers were reserved to the chairmen of Medicine and Surgery (the descendents of Drs Sladen and McClure) the relatively equal power of the various chairmen required a large,
cumbersome governing body. During that period, the power of a chairman probably exceeded that of a university chairman, since he controlled salaries, delineation of privileges, research, and education.

The first modification of this authority came over the question of how to provide leadership for programs which crossed departmental lines, such as the satellite medical centers, research and education. The answer at Henry Ford Hospital was to create directorships which ranked on paper, if not in prestige, with the department chairmanships.

The second, more profound discussion at Henry Ford Hospital over the last few years has paralleled similar developments in other large group practices. That is the question of the authority of the individual senior staff person within our organization. In the past, that authority, partly informal, was the result of the general scarcity of the specialized physicians we needed. This scarcity gave the physicians leverage. Since these shortages are now rare, an attempt has been made to formalize staff participation and elements of control. More than democracy as such, effective staff influence is the major issue. A Beaumont Hospital physician leader said to me last year that the two most successful hospitals in the Detroit area are the two least democratic—Henry Ford and William Beaumont. Since that time, both of those hospitals had gone through governance changes.

What Henry Ford Hospital has chosen at this time is a kind of quasi-democracy, with a controlled nominating process for a 12-member Board of Governors. All staff members vote yes or no to the nominees. Although our first use of this process was probably too closely controlled, it should improve as it evolves.

Many governance issues still merit discussion. For example, regardless of our kind of governance, with 440 doctors in multiple locations, are we too large to have a feeling of participation? Should the institution be divided into independent subunits, eg, satellites or tertiary care institutes? What is the best way for the medical professional group to work with the management group to achieve the best results for the institution? Do we have a double-headed monster, or will teamwork succeed? So far, it appears that teamwork will prevail. Should physicians become involved in management? Of course, if they want to lend their perspective to a complicated institution. Should nonphysician managers become involved in professional issues? Of course, if they are to bring their considerable skills to our advancement. I believe that such integration of these skills puts Henry Ford Hospital ahead of most other hospitals.

Issues of Growth for the Institutionalized Group Practice

From the perspective of Henry Ford Hospital, it has appeared that our colleagues in private practice have greater mobility to respond to population shifts. An immense number of doctors have moved their practices to the northern suburbs for this reason. Our ability to respond to those shifts has been encumbered by our size, inertia, and by the ethos of the group practice. Even when those obstacles are overcome, our mobility has been inhibited by the Certificate of Need process—a liability that far outweighs the increasingly evanescent advantages of the facility charge we have been permitted. While income from the facility charges has made it possible to meet the social responsibilities of our main downtown location, we might better have the freedom from regulation enjoyed by office-based practices.

Unlike most comparable clinics, Henry Ford Hospital has always provided primary care. In 1979, I calculated that over the previous 59 years, primary care constituted about 25% of our total effort during a time when the hospital staff grew from 12 to 418 members. That fact, however, should not disguise important changes in the shape of the group. Until World War II, the large group practices were surgical practices at the core; that characteristic distinguished them from the universities where the internists tended to thrive, presumably, among other reasons, because we internists have greater ability to thrive in a bureaucratic thicket. Henry Ford Hospital was no exception to this trend, and into the 1930s, we had more surgical specialists than internists. That condition has now changed. Internists make up from 1/4 to 1/3 of the staff, and when combined with other nonsurgeons, clearly constitute a majority.

The major implications of this situation are financial and political. All of the large group practices except the Scripps Clinic employ some form of income redistribution. When most of the staff was surgical, that method was more easily accepted; now it is more problematic and less palatable. The political issue is that while a disproportionate amount of revenue is generated by surgical specialists and some high technology internists, their impact on the system may not adequately reflect their contribution. The fact that departments at Henry Ford Hospital, unlike the universities, have not been able to divert their earnings to research and development creates another problem in our system. The opportunity to participate in our teaching activities has been a principal recruiting tool for persuading physicians to join us despite the high overhead of our practice. However, in the face of constraining external trends, the size of the educational enterprise has remained fairly stable while the staff has increased.

As a result, we find ourselves in a more palatable, yet less ideal situation. If we choose to meet whatever external trends confront us, we must be more effective in the way we allocate time and energy toward competing political issues. In the absence of a Cert of Need process, the opportunity for our colleagues in private practice may be the key to our future. Henry Ford Hospital is likely to have to rely on their perspective more than ever before.
As a result, individual teaching opportunities have diminished, and Henry Ford Hospital life looks much more like private practice. These facts, among others, were central to our decision to move away from the straight salary model which Henry Ford Hospital has followed for 70 years.

The closed panel kind of organization has some clear advantages that have helped us considerably in this last difficult decade.

1. It is easier to shape the staff to meet the institutional mission because it is possible to hire to meet needs. This is truer on the upward slope than on the downward slope. For example, when it was no longer viable to have an academic dental department at our main campus, closing that department was more difficult for us than it would have been under private hospital contractual relationships.

2. It is much easier to develop alternative delivery systems, because the staff already has the financial interdependency with each other and with the institution necessary to this kind of effort. Marketing such programs also is easier in our environment.

Future questions relate to the issue of whether, as we grow, we will always have the same relationships that we do now, especially in our mini-satellites. We have had a developmental, ongoing relationship with a PC group in Royal Oak. It appears that the more the world looks like us, the more we look like the world.

The final issue is whether the large group practices can and will meet their educational and social responsibilities. Taken as a whole, I find that their record of social responsibility is spotty. Some groups have avidly avoided accepting their share of Medicaid patients even in urban locations. Henry Ford Hospital has had a different tradition; our clinics and emergency room service the community. This policy carries a high price tag that requires having other profitable product lines to help support these activities. Whether reimbursement decisions by Medicare and others will continue to make this practice possible is a societal decision, not our decision. The cost of modern medical care exceeds the capacity of our institution to respond single-handedly to Henry Ford's first idea: care for all, equal charges, and no external help.

I am somewhat more sanguine about our prospects in education. Group practice is an ideal setting in which to carry out education. Even with the intention of the federal government to reduce graduate-education funding, some financing for education should come to our institution and be prudently spent here.

All the major group practices, including Cleveland, Geissinger, and Oschner Clinics and Henry Ford Hospital, are attempting to provide tertiary care at a time when tertiary care requires a lot of research and development money. Although we have our victories, the lack of consistent, if even limited, external support is a hardship. It is difficult for the state and federal governments, who seem to have the policy, "When in doubt, put it at the university," to categorize our institution. The fact that our Hospital has performed more kidney transplants than any other institution in the state is just one example that Henry Ford Hospital is a valuable resource that should be considered in governmental planning. Unfortunately, such is not always the case.

What are my conclusions after 20 years of involvement with hospital-based group practices? Should physicians work for a hospital? My answer is a qualified yes, although I fervently hope that the whole world does not go that way.

Yes, because the failure to integrate ambulatory and hospital activity is increasingly wasteful.

Yes, because the capital cost of technology requires a broad base of ambulatory support.

Yes, because hospitals are evolving into something more than the passive workshops for physicians.

Yes, because interdisciplinary institutions are easier to form.

Yes, because it is easier to respond to alternative payment mechanisms.

Yes, because it is a very natural alliance of interests.

But not for everybody. Group practice does not fit the temperament of all good doctors. It can lead to passive-aggressive reactions from the medical staff and can distort the appropriate relationship between managers and physicians. It could, if it became the dominant force in the industry, compromise physician earnings by not providing any other reference point.

At Henry Ford Hospital, we no longer see our future as a matter of going it alone. We will increasingly relate to other physicians, as we are with our ambulatory surgery at the West Bloomfield Clinic and with the Preferred Provider Organization.

Who knows? Ten to 20 years from now, institutions like Henry Ford Hospital may be seen as the last refuge of private medicine in this country.

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