ral inhibition of professional contacts outside of the group. The higher form of the group organization structure, the less would be the likelihood of extensive outside contacts. In addition, the general medical community has, in the past, exhibited an unwarranted animosity toward the members of groups further lessening the probability of outside professional rapport. It should clearly be noted that the result and not the cause is listed as a disadvantage. The result is the inbreeding of medical philosophy and viewpoint. That a group might become "stale" is a situation which should be avoided. Thus, the greater need exists for post graduate training and attendance at medical conferences. The latter tends to be an effective check against the former.

It was noted that the matter of professional cooperation and closeness of action were regarded as decided advantages of group practice. However, in the personal day-to-day relationships this advantage might be lessened by the internal friction within the group. The rigid education and training of the doctor demands of him a unique kind of individuality and independence which most often becomes deeply ingrained in his personality as well as in his professional approach. It is the personality factor, more than any other, which accounts for the possible bickering and internal squabbling. That this must be kept to a minimum for the benefit of the patient and the success of the group is abundantly clear. It might also be noted that the schools and colleges should modify their approach to emphasize the importance of the group endeavor.

Another disadvantage of group practice is that there is a restriction of the patient's opportunity to choose the services of a consultant. While on the face of it, the foregoing statement is true, it should be noted that the doctor's choice of consultant is reasoned to be vastly superior to that of the patient. The professional needs of the patient can be more objectively and scientifically evaluated by the doctor rather than by the patient. The patient is not competent to judge his professional needs in consulting services.

As a possible disadvantage of group practice, the argument has been rendered that patients are subjected to a much higher rate of consulting services and x-ray and laboratory analyses than for those patients who are treated by solo practitioners. The statement is statistically correct but implies that these consultation and laboratory analyses are unnecessary. To the degree that most groups are engaged in programs of preventive care, as well as therapeutic care, one would expect a higher consultation and laboratory rate. Physicians in group practice argue that earlier definitive diagnoses are made possible by these procedures. However, those who argue that such testing and consultative services are unnecessary readily admit that were they in an environment where such services were "at hand," they, too, would utilize them to a greater degree than their prevalent utilization in solo practice.

It should be remembered that the codes of ethical conduct written for members of the health professions were done so with the private, solo practitioner in mind. No individual doctor in his professional community would stand high in the esteem of his peers were he to advertise his services, solicit to enlarge his practice or gain the publicity of the communication media. And, yet, the group practice in its larger and more complex forms (HIP, Permanente, Group Health Cooperative, Ross Loos, Rip Van Winkle, etc.) all resort to these techniques mainly to approach occupational groups which might be "sold" the health program offered by the group practice. The question of unethical conduct as a disadvantage should in fairness be listed pending a re-evaluation of the ethical codes in the light of present day group practice.

Since the emergence of group practice as a dominant force in the administration of health services, the matter of access to general hospitals by the members of the group has been the subject of severe and heated controversy. Sometimes this controversy can become so acute as to spill out in full display on the front pages of our newspapers.[14] Some physicians contend that only the hospital environment offers the best opportunity for the advancement and interchange of professional knowledge and not the group. This group contends that only the hospital is the place for the highest quality of patient care. "That members of a group practice should be denied hospital privileges is unthinkable from the public's point of view."[15] In prior discussions, the concept of group practice attached to a hospital environment was held to be a distinctly favorable situation.[16] One must conclude, therefore, that the relationship of the general hospital and group practice is a disadvantage but that its cause lies solely within the province of intra-professional relations. That the effect is a subject for public concern is well documented.

Considered as a decided disadvantage to the very well trained specialist in group practice is that his income level is decidedly lower than that of a solo practitioner in