19th century general practitioner could render the entire spectrum of then-known medical services, but in 1966 we cannot expect and we should not expect an internist to perform heart surgery.

The growth of specialization has been accelerating. In 1940, 21 percent of the doctors in private practice were specialists. In 1964, 69 percent were specialists. Four out of five medical students are in training for specialty practice. The idealized general practitioner is rapidly disappearing from the American scene.

Along with this trend toward specialization is the increasing dependence of the medical profession on expensive diagnostic and therapeutic equipment, usually available only in such institutional settings as hospitals or group practice clinics. Therefore, physicians are increasingly establishing offices within or in close proximity to hospitals.

What it comes down to is this. Advances in medical knowledge and technology mean that medicine can no longer be practiced efficiently without organization of medical personnel and facilities and that teamwork is becoming increasingly important as a necessary element to both efficiency and to quality. Specialization without cooperation is costly, inefficient, and detrimental to quality care. These principles are recognized in our better hospitals but the issues are continuously and deliberately being confused by such empty slogans as "socialized medicine," "free choice of physician," "interference with the doctor-patient relationship," and "interference with the practice of medicine."

Solo, individual practice in medicine is not only inefficient but of relatively poor quality as well. Quality care requires standards and procedures for evaluating performance. This kind of review and evaluation of the practice of medicine is all to the good. We need more of it.

Dr. George Baehr, former president of the New York Academy of Medicine, warns that "Under the prevailing system of solo practice, there are no enforceable standards of quality, no supervision of professional perfomance, no determination of errors of omission or commission in practice, no measurement of waste in unneeded services and costs * * *."

Some measurement of both waste and lack of standards of professional performance is indicated by the experience of Federal employees under their multiple choice health benefits program. Federal employees may elect their health benefits coverage under three options, namely: Blue Cross-Blue Shield, commercial insurance, or a comprehensive direct service group practice prepayment plan such as the Kaiser Foundation health plans on the west coast and in Hawaii, The Health Insurance Plan of Greater New York, Group Health Association in Washington, D.C., and others. Those electing Blue Shield coverage for surgery had 70 surgical procedures per 1,000 subscribers for the second contract year, November 1, 1961, to October 31, 1962. Those choosing group practice plans had 39 surgical procedures per 1,000 subscribers.

Confirmation that these statistics for group practice plans reflect a substantial reduction in unnecessary surgery comes from medical audits which have been conducted by the Schools of Public Health of Columbia University and of the University of California at Los Angeles. These medical audits indicate a substantial amount of unnecessary surgery under prevailing patterns of practice, particularly for hysterectomies, tonsillectomies, and adenoidectomies.

A study sponsored by the University of North Carolina and the Rockefeller Foundation during 1953-54 among general practitioners in the State indicated the following weaknesses among this group of solo practitioners: (1) limited history taking; (2) limited physical examinations; and (3) limited use of aids to diagnosis.

We do not claim quality medical care automatically and necessarily results from the association of doctors and other paramedical personnel in group practice but we do believe group practice provides the necessary framework within which quality control can be built in.

Herman and Anne Somers, in their classic in the field of medical economies, "Doctors, Patients, and Health Insurance": point out that:

"The reasons for the positive effect of group practice on quality are both obvious and subtle. The structural or institutional factors include medical center orientation, higher standards of physical equipment and facilities, record-keeping, group standards of professional procedures, easier access to a larger range of specialized personnel, more frequent exchange of professional judgment, more time off for refresher and post-graduate courses, etc."

Dr. Gunner Gunderson, former president of the American Medical Association, has said, "There is no question that group practice can provide better medi-