

Group practice at Baylor University Medical Center

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The private practice of medicine allows doctors to ply their trade alone or in arrangements with other physicians. In the early part of the century, physicians typically practiced alone, many out of their homes. Even in the 1980s, almost two thirds of practicing physicians in the USA were in solo practice. Today <40% of physicians practice alone, and the percentage has been steadily declining (1). In fact, since 1985, more physicians are signing up with group practices than are accounted for by the number graduating from medical schools. This includes established physicians who had previously worked alone or in small groups who are now merging with or being acquired by group practices (2).

When a physician completes formal training, he or she can decide to practice in a group or alone. This choice may pose a dilemma. Medical students and medical residents have studied the art and science of medicine; however, the framework in which medicine is practiced has not been emphasized. Group practices include multispecialty associations and single-specialty groups. Of the two, the fastest growing arrangement is of physicians of a single discipline. Whether a physician works alone, in tandem with several other physicians, or in a large group practice is determined largely by community and cultural influences. And over the past several decades, as noted, the predominant practice style has shifted.

Why the change? Traditionally, independence and autonomy were valued and reinforced by the educators and leaders of American medicine. While these values may still be honored, collaboration and sharing of opinions have become increasingly important, in part due to the fragmentation and specialization of medicine.

The business aspect of medicine has also been a driving force for consolidation and collaboration of the practice model. Beginning and building a successful practice has become more challenging. The insurance industry has contributed to this with its intricate contracts, credentialing hurdles, and capitated patient populations. Another factor involves the increased complexity of the medical practice. Typewriters have been replaced by computers, Occupational Safety and Health Administration guidelines dictate practice policies and standards, employees fall under mandates from human resource specifications, and contracts of office leases are written in legal jargon that many physicians find difficult. Even more difficult are the managed care contracts that typically require interpretation by professional law firms. In addition, many new physicians emerge from training programs deeply

in debt, with financial uncertainties. Larger groups of physicians offer assistance with these issues and can also offer more extensive retirement plans, insurance coverage, and disability protection. It is not surprising that medical graduates often choose to begin their careers under the auspices of an established, organized group of physicians who can offer financial and professional security (Roy Perkins, MD, correspondence, September 21, 2000).

HISTORY OF GROUP PRACTICES

Group practices were first refined in the early 1900s in Rochester, Minnesota. Drs. Will and Charlie Mayo are credited as the founders of group practice in America or, some would say, the founders of *private* group practice. Prior to their clinic, collaborative collections of physicians were found only in association with academic centers and universities. Those in private practice, for the most part, worked alone.

The Mayo brothers had a different vision. They promoted the specialization of medicine and the cooperation of different specialists, working together, to bring a collective wisdom to the patient. Dr. Will Mayo described their philosophy: "Group medicine is not a financial arrangement, except for minor details, but a scientific cooperation for the welfare of the sick" (4).

Other early group practice pioneers included the Lahey Clinic in Massachusetts, Oschner Clinic in Louisiana, and Palo Alto Clinic in California. All of the early groups were launched by strong, committed, visionary physician leaders who foresaw a multidisciplinary approach to patient care as potentially superior to that rendered by a single physician. Teaching, education, and clinical research priorities were also thought to be more effectively pursued in group arrangements. Teaching activities, in particular, were believed to enhance professional skills, and clinical research generated articles for publication that fostered recognition through the medical literature.

Paul Starr wrote in his book, *The Social Transformation of American Medicine*, that these early group practices were expected to become "harbingers of a new order in medical care. It was thought

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then that the virtues of ‘cooperative teamwork’ and ‘group medicine’ would bring about this change, and that “individualism in medical care had had its day” (3). This may have been prophetic but has been slow to occur, and “individualism” still thrives today in the private practice of medicine in America.

Physician group practices at Baylor University Medical Center (BUMC) have developed and evolved over the past 100 years. Keeping with the national custom, early in the history of the center, most physicians practiced their trade individually. Still, experiments with group practice did take place. Some of those early groups have continued, some have prospered, and at least one has flourished. Today there are many group practices, and their ranks are swelling. The motivations, advantages, and disadvantages of group practice are explored in this article.

W. B. CARRELL MEMORIAL CLINIC

One of the early group practices in Dallas, Texas, was built around the specialty of orthopaedic surgery. A Dallas general surgeon, Dr. William Beall Carrell, served in World War I and during that experience developed a new focus and passion. His association with English orthopaedic surgeons while he was stationed in France directed his attention to the skeletal system. After the war, he went to England for additional training in the burgeoning specialty and then returned in 1919 as Dallas’ first orthopaedic surgeon. He would personally train the second, third, and fourth orthopaedic surgeons in Dallas.

Dr. Carrell was also the originator of the Texas Scottish Rite Hospital for Children. This clinic was designed to provide care for “crippled children” at no charge. The endemic of polio in the early 20th century left many disabled and in need of devoted attention. Dr. Carrell felt a calling to provide for this group of children. For some time, the physician staff of the hospital and members of the Carrell Clinic were one and the same.

The clinic also cared for many private patients from Dallas and North Texas. It grew in prestige and in numbers. Dr. L. Ray Lawson, who would later serve as a leader of the group, recalled that the members were “extremely cohesive” (Ray Lawson, MD, interview, September 6, 2000) (Figure 1). Each physician had “the same basic concept of practice—a real concern for the care of patients.” Dr. Carrell had expressed that vision at the groundbreaking of the Texas Scottish Rite Hospital for Children in 1921: “We are not interested in promoting any surgeon’s personal activities but wish the clinic to stand for what it is, a contribution . . . to the crippled children” (5).

By the 1980s, the practice of orthopaedic surgery had changed under the influence of total joint replacements and arthroscopy. These technological advances altered the surgical complexity and the insurance reimbursement of the specialty. Many orthopaedic surgeons narrowed their expertise, often to a single joint, and the groups evolved into a collection of joint-oriented subspecialists. No longer were the partners equally trained and capable in the

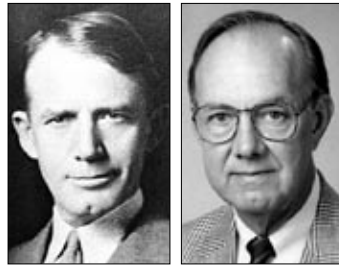


Figure 1. Drs. William Beall Carrell and L. Ray Lawson of the W. B. Carrell Memorial Clinic.

Table 1. Physicians currently practicing with the W. B. Carrell Memorial Clinic

John A. Baker, MD	Andrew B. Dossett, MD
William A. Bruck, MD	Sumant G. Krishnan, MD
W. Z. Burkhead, Jr., MD	L. Ray Lawson, MD
Daniel E. Cooper, MD	James R. Sackett, MD
Eugene E. Curry, MD	Richard D. Schubert, MD
R. Stephen Curtis, MD	Robert D. Vandermeer, MD

treatment of all aspects of the skeletal system. Some of the subspecialty partners became uncomfortable dealing with general orthopaedics. Distribution of income was also challenging as disparities in the reimbursement of the new procedures became evident.

In contrast to other specialties and groups, managed care in the 1990s had little impact on the Carrell Clinic. Reputation and demand for the clinic’s services allowed it to leverage against the insurance companies, and when terms were judged unfavorable, the clinic would not participate with a particular insurance plan. This favored the finances and viability of the clinic, though patients and referring doctors could be left disenfranchised. To be fair, other group practices and even solo practitioners frequently combated the insurance companies in a similar fashion.

The Carrell Clinic continues to grow in numbers and reputation. Leadership, consistent management, and active participation by all members in monthly business meetings have contributed to the success and cohesiveness of the group (Table 1).

ORTHOPEDIC ASSOCIATES

In the late 1950s, Drs. F. Leon Ware, Marvin Knight, and Dan Ray Sutherland originated a group of orthopaedic specialists that came to be known as Orthopedic Associates. They were joined in 1960 by Dr. John B. Gunn (Figure 2). Dr. Ware was touted as an outstanding educator and did much to develop the orthopaedic teaching program of BUMC. Drs. Knight and Gunn were early pioneers in sports medicine and worked with the Dallas Cowboys football franchise and the Dallas Blackhaws, a professional hockey team. The group also cared for many of the worker’s compensation cases in Dallas and served as a special consultant to Texas Instruments.

As subspecialization crept into the field of orthopaedics, Orthopedic Associates recruited new members with expertise in the hand, shoulder, hip and knee, back, and foot. Single-joint specialization provided focused expertise to the community but challenged the group with the added complexities of call coverage and disparate productivity. These issues led to the splintering off of the back specialists in recent years.

As a former leader of the group, Dr. John Gunn recalled the attributes of the association. An emphasis on teaching has benefited orthopaedic residents, the members of the group, and the community they serve. Several new innovations were popularized and refined by the physicians of Orthopedic Associates, including total joint replacements and ligament transfers. Monetary allowances for conferences and continuing education have kept the members on the forefront of new developments in the field (John Gunn, MD, interview, July 3, 2001) (Table 2).



Figure 2. Drs. F. Leon Ware, Marvin Knight, Dan Ray Sutherland, and John B. Gunn of Orthopedic Associates.



Figure 3. Drs. Raleigh W. Baird, Harold M. Doolittle, and George Fosmire of Dallas Medical and Surgical Clinic.

Table 2. Physicians currently practicing with Orthopedic Associates

Shawn C. Bonsell, MD	J. Mack Lancaster, MD
James W. Brodsky, MD	Virgil B. Medlock, MD
Phillip E. Hansen, MD	Christian Royer, MD
Carl L. Highgenboten, MD	Charles S. Rutherford, MD
Shelton G. Hopkins, MD	

DALLAS MEDICAL AND SURGICAL CLINIC

Dallas Medical and Surgical Clinic began as a partnership in 1905 between two Dallas physicians and later became Dallas' first multispecialty clinic. Dr. Raleigh W. Baird was a diagnostician and was described as the "chief drawing card." Dr. Harold M. Doolittle was a Mayo Clinic-trained general surgeon attributed with impeccable judgment and unquestionable integrity (6) (Figure 3). This partnership would grow over the next 20 years with the addition of specialists in urology, obstetrics, pediatrics, gastroenterology, radiology, and pathology. The formal structure for the Dallas Medical and Surgical Clinic was put in place in 1921.

The clinic was said to enjoy economic and organizational advantages. Compensation differences between senior and junior partners, however, led to controversy. The Great Depression also stretched the finances of the group and led to a reorganization and the loss of some members (6).

Additional strains occurred in 1931 when the Dallas County Medical Society investigated novel contracting arrangements between the clinic and two large employer groups. The contracts called for prepayment for medical services from the Federal Reserve Bank and the Dallas Street Railway Employees Benefit Association. Prepaid medical care was a new concept at the time and an unpopular one with other physicians in the community. Deliberations were undertaken, and the medical society ruled that the clinic had been unethical. The reputation of the clinic was tarnished (7).

The clinic survived the stressors of the 1930s and attracted additional physicians of varied specialties. Dr. George Fosmire, a surgeon who became a leader of the group, cited "economies of scale and organizational efficiencies" as inducements for membership (George Fosmire, MD, interview, July 12, 2000). The initial costs of opening an office had become formidable. Dr. Fosmire recalled his entry into private practice: "I had just returned from overseas missionary service. The Dallas Medical and Surgical Clinic afforded me an opportunity to open a practice without a financial outlay, which I lacked at the time."

While multispecialty groups in other cities grew in numbers and stature, the Dallas Medical and Surgical Clinic struggled with membership. In the 1980s a significant block of internists left, weakening the structure and solvency of the clinic. Financial inequities among the physicians were said to be a factor, but no other multispecialty practice in Dallas at the time had found the solution to this problem. The proliferation of multispecialty groups was inhibited by the success of voluntary hospitals and their affiliated physicians in the Southwest. Large, successful hospital systems obviated the need and the advantage for organized groups of private practitioners in Dallas and other western communities (7).

A real estate foray also strained the finances and relationships of the physicians in the group. Land around the clinic was bought and financed speculatively with interest rates that floated. When rates increased above the value of the holdings, difficult decisions were required.

Eventually the Dallas Medical and Surgical Clinic shrunk, relocated, and affiliated with another Dallas hospital system. Dr. Fosmire added this explanation for the downfall of some multispecialty group practices: "Texans are frontier-like. Texas physicians seem to prefer individual personal control over their practice to such a degree that, until recently, group practice did not appeal to most of them" (George Fosmire, MD, interview, July 12, 2000).

MEDPROVIDER

In contrast to the collection of different specialists at the Dallas Medical and Surgical Clinic, most later groups formed around single specialties. The origin of one such group illustrates the forces that drew physicians together in the later part of the 20th century.

Several dozen internal medicine physicians at BUMC began regular meetings in the early 1990s to explore the feasibility of a combined group practice. At that time, managed care policies by large insurance companies were beginning to exert an influence in the Dallas market. These physicians were concerned about being at a disadvantage during negotiations with insurance companies. The increasing complexity of the business of health care was also recognized. Many of the physicians in those initial discussions sought relief from the management of their practices. Their education in the science of medicine had overlooked the tools now required to handle the new professional environment. The general sentiment in the early meetings was that collaborative groups could more practically avail themselves of needed lay expertise and could be more effective in negotiations.



Figure 4. Drs. W. Mark Armstrong, D. Michael Highbaugh, Paul E. Madeley, Paul A. Muncy, Paul A. Neubach, Weldon L. Smith, Jr., and F. David Winter, Jr., the founding members of MedProvider.

Original meetings of the group that would come to be known as MedProvider were lively and well attended. Many ideas and thoughts were brought forth as to how a merger or consolidation of practices might occur. Progress in the discussions, though, became ponderous. After 12 months of meetings, participation and enthusiasm waned. At that point, I independently engaged the services of accounting and legal counsel. A written plan of organization was developed and refined into an acceptable framework. Seven members of the original committee signed on, and MedProvider was chartered in 1993 (Figure 4).

An interesting story relates to the derivation of the name MedProvider. Business enterprises that deal in name selection and certification are quite costly. National search and copyright firms charged \$50,000 at the time, and statewide firms were only a fraction below this. However, a name that was not already registered in the state of Texas could be certified for a \$25 filing fee. The challenge was finding a designation that had not been claimed and previously registered. Multiple inquiries to the state office in Austin led to the realization that combined hybrid names were less likely to have been reserved. At the time, lyrics from the Michael Bolton song "Soul Provider" told of providing "soul" to another. An analogy to medicine seemed applicable, and a quick search of registered names in Austin led to approval. The name MedProvider was coined.

Once organized, MedProvider centralized billing and collecting functions. Group purchases were also negotiated collaboratively. Office settings and personnel were initially left unchanged. Contracting advantages were also limited due to the relatively small size of the group. Expansion of the group became an early goal.

Many internists expressed interest in joining MedProvider. Some had difficulty with the thought of losing control and the autonomy of their practice. Group efficiencies and unified contracting were desired, yet commingling of finances seemed threatening. For instance, one prospective member asked if accounting could keep track of dictation and properly charge each member for only his or her lines and letters of transcription. The candidate was encouraged to remain in solo practice.

The trade-off between autonomy and group advantages was realized by some. By the end of the first year, MedProvider had grown to 17 members and was being courted by several organizations who desired association with a group of primary care providers. After lengthy discussion with several suitors, MedProvider aligned with Baylor Health Care System (BHCS) as a founding division of the HealthTexas Provider Network. The group has since expanded to 37 physicians and remains in partnership with Baylor.

DALLAS NEPHROLOGY ASSOCIATES

Drs. Alan R. Hull and Ronald C. Prati founded the single-specialty nephrology group Prati, Hull, and Associates in 1970; with the addition of Dewey L. Long and Thomas F. Parker III, it later became Dallas Nephrology Associates (Figure 5). The group has had only 4 presidents: Drs. Alan R. Hull, Martin G. White, Pedro Vergne-Marini, and Ruben Velez. When the group was founded, the subspecialty of nephrology was new. In fact, the first board examinations would not take place until 1971. Dialysis for the treatment of kidney failure was a new technique at the time, performed only in university settings.

Dr. Hull was the first president of Dallas Nephrology Associates, a role he served for 15 years. Many attribute the success of the group to his efforts. He was particularly known for his willingness to be fair to all group members and for being an excellent businessman. With the consent of the other partners, he developed a business model that paid all partners the same whether a doctor supervised dialysis all day or traveled from hospital to hospital in consultation. At that time, no one hospital had sufficient activity to support the clinical or economic activities of a single nephrologist. Thus, initially the members sought and obtained privileges at all Dallas-area hospitals. Productivity of the physicians was aligned to maximize value to the group (Tom Parker, MD, interview, January 15, 2003).

The initial members of the group had all trained at the University of Texas Southwestern Medical School under the tutelage of Dr. Donald W. Seldin, and as nephrology fellows, they enjoyed studying and working together and seeing patients while maintaining academic and research activities. Those early members, along with others attracted into the specialty of nephrology in the 1970s and 1980s, enjoyed the application of the science and physiology to the practice of medicine. Under Dr. Hull's leadership, the academic interests of nephrology involving clinical research were combined with clinical practice. Labeled the Godfather, Dr. Hull continues to be a source of inspiration and wisdom even in his retirement (Ruben Velez, MD, interview, December 4, 2002).

The group enjoyed camaraderie and worked well together. Important early decisions of Dallas Nephrology Associates included supporting academic activities and research, as well as the concept of sequestering a portion of income for future growth. It was also planned to grow the group as demand in the community became apparent, and a plan and commitment for multiple sites was charted. This included multiple offices, dialysis clinics, and a transplant program. In 1981, Dr. Vergne-Marini successfully initiated the first organ transplant program in a private hospital. Dallas Nephrology Associates was also innovative and became one of the first nephrology groups in the country to build community dialysis centers.



Figure 5. Drs. Alan R. Hull, Ronald C. Prati, Dewey L. Long, Thomas F. Parker III, Martin G. White, Pedro Vergne-Marini, Ruben L. Velez, and Michael Emmett of Dallas Nephrology Associates.

After training at Southwestern Medical School and completing 3 years of military service, Dr. White became chief of dialysis at the Dallas Veterans Administration Center from 1971 to 1975. He built a dialysis program that included acute care, in-hospital dialysis, and training for home dialysis. Dallas Nephrology Associates was one of the first nephrology groups in the country to receive a government contract for dialysis. Dr. White was also involved in the first kidney transplant program in the Veterans Administration in the Southwest.

In 1975, Drs. Hull, White, and Paul Peters, Sr., established a nonprofit organ recovery organization named Southwest Organ Bank. With support from the University of Texas Southwestern Medical Center, the organization increased the availability of kidneys for transplant. Dr. White was the founding president and remained in that office until the year 2000. During those years, Southwest Organ Bank became one of the top organ procurement organizations in the country, producing more donated organs for transplant than all but a handful of similar organizations. In many ways, this contributed to Dallas' becoming a national center for organ transplantation. As Dr. White explained, "Even the most skilled surgeon will only be as successful as the organ supply permits" (Martin White, MD, correspondence, December 29, 2001).

Dallas Nephrology Associates has grown into a citywide group that includes 48 kidney specialists. It has become the largest group of organized nephrologists in the country. Dr. Tom Parker attributed this success to strong, charismatic leadership. The strategic placement of partners in emerging hospitals also helped capture the market in Dallas. A member of the group became the director of dialysis in each new hospital in the city (Tom Parker, MD, interview, January 15, 2003).

Dr. Michael Emmett (Figure 5) added that the leaders have always been excellent businessmen. The practice of nephrology was organized to allow for a blend of patient care, research, and academics. All partners shared the same call schedule and made the same income (Michael Emmett, MD, interview, January 29, 2003). Finding talented partners has been a challenge, but those

who join tend to stay. Very few members who became partners have ever permanently left the group.

Despite its success, Dallas Nephrology Associates was to have its own unique challenges. Partnership with a large, publicly traded Fortune 500 company unraveled around the issue of control over freestanding dialysis centers. Competing dialysis units were built by the nephrologists, a lawsuit ruled against the physicians, and restitution eventuated. The current president, Dr. Ruben Velez (Figure 5), stated that the lawsuit "brought the group together. We became tight" (Ruben Velez, MD, interview, December 4, 2002). Communication and relationships among the physicians improved to an even higher level. Dallas Nephrology Associates pioneered quality projects, which have been modeled by other groups around the country. Protocols have standardized the delivery of care to patients, and electronic medical records give instant access to patient information.

Dallas Nephrology Associates remains a leader in the delivery of nephrology services, including dialysis, expert nephrology consultations, and transplant medicine, to the patients and physicians of North Texas.

CARDIOLOGY

The first cardiology group at BUMC formed around Dr. John W. Hyland in 1971. Originally compensated under a professional services contract by the hospital, he later developed cardiology from a private-practice perspective. Dr. Jerry Miller, a radiologist at Baylor during that era, is ascribed to be the pioneer of private practice for hospital-based physicians in Dallas. At that time, radiologists, anesthesiologists, pathologists, and chiefs of departments were commonly compensated by hospitals. Dr. Miller championed separate billing by physicians and was ultimately successful, but in his quest he lost his position at Baylor. According to Dr. Hyland, independent billing by physicians was critical for the development of group practices in that pooled funds allowed the nurturing of new partners and practices (John W. Hyland, MD, interview, May 15, 2001).

As the first to perform cardiac catheterization procedures at Baylor, Dr. Hyland rapidly became overwhelmed with referrals from other physicians. Drs. James L. Matson and Rolando M. Solis were recruited to share the load. A fellowship program was also developed to train new cardiologists, an activity that was funded by the group.

The proliferation of coronary bypass surgery placed enormous demands on the new cardiology group. Cardiac catheterizations left little time for other activities. Dr. Charles L. Harris was hired to assist with consultations and the readings of echocardiograms. This raised the first dilemma of cardiology group practice. Procedures performed in the catheterization laboratory were more lucrative than other cardiology functions, yet the other duties were required to fulfill the specialty of cardiology. A sharing arrangement was devised to shift funds from the procedures to the less remunerative duties, but as more nonprocedural cardiologists were hired, this arrangement became contentious. Splintered factions, resignations, and defections to other groups resulted.

By the early 1990s, the field of cardiology changed further. No longer an organ-focused consultative service, newer procedures and new subspecialties would forever challenge and alter the practice of cardiology.



Figure 6. Drs. John W. Hyland, James L. Matson, Rolando M. Solis, Charles L. Harris, Charles M. Gottlich, and Kevin R. Wheelan of HeartPlace.

HEARTPLACE

Dr. Hyland's original cardiology group, Dallas Cardiology Associates, changed its name to HeartPlace and took a new direction in 1990 (Figure 6). Dr. Hyland served as president from 1971 until 1990, at which time he stated, "I got tired of the business." Dr. Charles Gottlich would serve the next 5 years and is credited with building up the administrative staff by recruiting and hiring more employees and setting policies. To influence productivity among the physicians, compensation was changed from its historic allotment based on seniority to a production-based model. Open financial disclosure was implemented, and regular financial reports were made available to the members (Kevin Wheelan, MD, interview, April 21, 2000).

HeartPlace moved its offices to the Baylor Tom Landry Center, added additional physicians, and planned outreach programs. The group realized a need to expand in scope and offer more outpatient services. Yet, as the group expanded in scope and services, pressure was mounting from new competition.

In 1995, Dr. Kevin Wheelan took over as leader. Organizational planning and business principles were formalized. Expert subspecialists in electrophysiology and invasive procedures were cultivated and recruited. The group grew in numbers and developed a more sophisticated business administration.

A desire to leverage against managed care companies led to expansion of the group beyond the Baylor campus. The goal was to develop a regional integrated cardiology group. This required capital, and the group banded with a practice management company that shared thoughts of taking the entity into the public markets. This strategy, which was later reversed, cost the group considerable assets and led to the dissatisfaction and defection of several members.

After regrouping, HeartPlace rekindled its plan to increase in numbers and locations concentrated around the metroplex. Managed care's influence was growing and competition from other cardiologists was threatening, and to counter, the organization sought the creation of "brand awareness." This, along with expansion, was thought important to preserve the financial viability of



Figure 7. Drs. John R. Schumacher, Jerrold M. Grodin, Robert L. Rosenthal, and Stephen B. Johnston of Texas Cardiology Consultants.

the group. Size, identity of the group, and geographical distribution were targeted to provide leverage in the marketplace.

As HeartPlace grew in size and complexity, it encouraged the physician members to attract and retain their own patient base. Identification of patients with a single physician provided better continuity of care and became an objective and goal of the group.

Not everything worked as planned. In addition to the collapse of the relationship with the practice management company, other challenges occurred with satellite offices. Synergy did not always follow, both with group culture and with acceptance of the satellites on managed care plans. Business office management issues, along with personnel incompatibilities and the difficulty in managing remote locations, led to the closing of several offices. Dr. Hyland himself retired and subsequently joined a competing cardiology group. He later spoke of having "different goals and different ideals."

Through a period of tremendous changes in the medical community, HeartPlace survives as a strong force of over 50 cardiologists. It has realized the advantage of group purchasing and negotiations and has developed an extensive business infrastructure that offers expertise and stability to the group. Physicians are left to focus on the practice of cardiology, and patients can access the subspecialties of cardiology in what has been referred to as "one-stop shopping." A joint venture with BUMC and other cardiology and vascular groups was spearheaded and evolved into the Baylor Hamilton Heart and Vascular Hospital, which may extend the influence of all involved to increase the quality and efficiency of cardiology and vascular care in our community.

TEXAS CARDIOLOGY CONSULTANTS

Drs. John R. Schumacher, Jerrold M. Grodin, and Robert L. Rosenthal completed their cardiology fellowships at BUMC in 1980. Lacking an offer from the hospital's only cardiology group at the time, they each began careers in solo practice. Three years later, encouraged by the chief of medicine, Dr. John S. Fordtran, they formed the nucleus of a new cardiology group, along with Dr. Stephen B. Johnston (John Schumacher, MD, interview, July 14, 2000) (Figure 7). Their vision was of a cardiology practice built from referrals cultivated at smaller hospitals and communities. Each spent many hours on the streets and highways of North Texas, consulting with outlying physicians. Dr. Grodin found a way to combine business with pleasure as he towed his bass fishing boat to clinics in smaller towns adjacent to fertile lakes. Consulting in the mornings and fishing in the afternoons, he developed a strong following among the patients and physicians of East Texas (Jerrold M. Grodin, MD, interview, May 21, 2003).



Figure 8. Drs. Merrick Reese, J. R. Williams, John C. Bagwell, Lloyd Kitchens, and Lewis A. (Skip) Duncan of Texas Oncology.

To complement and parry direct competition with the established cardiology group at BUMC and to grapple with burgeoning managed care pressures, they successfully built a wide geographic distribution of referrals. They likened their strategy to that of the airlines' "hub-and-spoke" model. As this approach succeeded, more cardiologists were required and, in time, the practice grew. Several members concentrated on performing procedures at downtown Baylor, and others spent time traveling and consulting. Though reimbursements favored procedural work, the value of each role was appreciated and salaries were equalized, shifting income from those who stayed in the catheterization laboratory to those who "rode the circuits." The division of labor was thought to maximize efficiency, and the distribution formula affirmed the stated recognition of the value of each member. A steady influx of patients from communities around Dallas flowed to the group and to the medical center.

With the many members of Texas Cardiology Consultants traveling in different directions, cohesiveness of the group was a challenge. Frequent general meetings were found to be important to maintain communication and remind doctors of the vision and of the value of each role. Presentations of financial trends and referral sources helped to reinforce the group's philosophy. In addition, each shareholder was made a board member and an equal member of the group.

In the 1990s, under the influence of managed care, Texas Cardiology Consultants joined forces with a group of cardiothoracic surgeons and a group of vascular surgeons. The thought was to increase the points of entry into the group and to obtain contracting leverage with the insurance companies. Contracting advantages never materialized, and the alliance later fell apart. One member concluded that "bigger is not better."

Much of the culture that endured was established by the early founders. Dr. Schumacher summarized their approach: "Hire the best doctors, find a way to get along with them, and develop pride in the group." Dr. Grodin described the group as "more of a family than a business." The group practice continues to expand and is a participant with the other cardiology groups and BHCS in the Baylor Hamilton Heart and Vascular Hospital.



Figure 9. Drs. Daniel E. Polter, J. Kent Hamilton, Daniel C. DeMarco, Harry E. Sarles, Jeffrey Crippin, Jeffrey S. Weinstein, and Blair Conner of Digestive Health Associates of Texas.

TEXAS ONCOLOGY

In 1972, Drs. Merrick Reese and J. R. Williams formed a partnership, beginning what would become the largest oncology group in the country. Drs. John C. Bagwell, Lloyd Kitchens, and Lewis A. (Skip) Duncan thereafter joined what initially was called the Medical Oncology Group (Figure 8). The initial motive was to provide coverage and assistance in attending to the burgeoning load of oncology consults. As the group practice grew, it was noted that other specialties, such as urology, had grown and then contracted as similar specialists set up practices in the suburbs and small towns surrounding BUMC. To combat this competitive threat, a strategy was devised to expand the group around the state. Incentives were built into the compensation formula to reward partners who signed up for out-of-town clinics. As the group expanded at BUMC and in its outreach clinics, the need for additional oncologists became a pressing issue. A fellowship program was eventually set up and funded by the group to cultivate and train new partners. Texas Oncology currently has 190 to 200 physicians throughout the state.

DIGESTIVE HEALTH ASSOCIATES OF TEXAS

Dr. Daniel E. Polter was the first gastroenterologist at BUMC in 1971. For several years, he was the only one. Call was shared with an oncologist, Dr. Merrick Reese, an arrangement they labeled "blood and guts" (Daniel E. Polter, MD, interview, July 31, 2001). Dr. Charles Walker was later recruited, followed by Drs. J. Kent Hamilton, Daniel C. DeMarco, Harry E. Sarles, and Jeff Crippin. Drs. Jeffrey S. Weinstein and Blair Conner were added shortly thereafter (Figure 9). This group felt the need to formalize and expand in the 1990s when managed care pressures grew. As other gastroenterologists organized, competitive pressures developed. The goal was to organize into one economic unit that could negotiate more effectively and hopefully find some efficiencies.

To date, Digestive Health Associates of Texas includes 45 gastroenterologists scattered around the Dallas-Fort Worth metropolitan area. An early strategy was to avoid capitated contracts. This cost some of the members significant portions of their practices, but these practices recovered.



Figure 10. Drs. Charles Walker, Charles T. Richardson, Douglas R. Thurman, Nicolae (Mickey) Weisz, Esmail M. Elwazir, and William Gregory Hodges of Texas Digestive Disease Consultants.

The gastroenterologists in the group have been freed from many of the worries of the business aspect of medical practice. Patients are said to benefit from quality control practiced by the group.

TEXAS DIGESTIVE DISEASE CONSULTANTS

Dr. Charles Walker, an original partner of Dr. Dan Polter, split off on his own in the 1980s. In 1989 he persuaded Dr. Charles T. Richardson to leave his appointment at the University of Texas Southwestern Medical School and Veterans Administration Medical Centers to form a new group. They later recruited Drs. Douglas R. Thurman, Nicolae (Mickey) Weisz, Esmail M. Elwazir, and William Gregory Hodges to band together in a group that would later become a part of Texas Digestive Disease Consultants (*Figure 10*). Dr. Walker's vision was to organize a large group of gastroenterologists from disparate locations to compete for managed care contracts. Cigna health maintenance organization (HMO) and Heritage Southwest contracts were signed and brought the group a steady supply of patients. As HMO management intensified and remuneration diminished, these contracts became less desirable. Today the group is steering away from HMO contracts, as are most of the rest of the physicians in Dallas.

Dr. Charles Richardson likened group practice to a marriage: "You must be able to trust your partner" (Charles Richardson, MD, interview, August 1, 2001). Texas Digestive Disease Consultants fosters private practice principles and functions like a fellowship for new members, offering emotional guidance and support in addition to assistance with procedural techniques.

TEXAS NEUROLOGY, PA

Baylor neurologists organized into a formal group in 1994. The specialty had existed at BUMC for several decades, though only as a collection of solo practitioners. In the early 1980s, Dr. Gary Tunell (*Figure 11*) tried to put together a group, but his two partners, Dr. Dave Davis and Dr. Stephen Brooks, ended up leaving the city. Active in teaching at the University of Texas Southwestern Medical School, Dr. Tunell's second approach was successful, and he recruited his next three partners from the residency

program: Drs. Stephen Herzog, Alan Martin, and Bruce Jenevein. Drs. J. Ted Philips and Daragh Heitzman would later join, and a corporate structure was adopted. The goal at the time was to lower overhead costs, provide an organization that could attract new partners, pool resources to obtain business expertise, and acquire bargaining power with managed care forces. Drs. Merrick Reese and Martin White are credited with providing important guidance in the early formative stages.

Soon after Texas Neurology became a corporate entity, two of the original partners left the group. Finances and personal relationships were strained, but fortunately for the group the two partners both rejoined after a short interlude. Thereafter, buy-in and buy-out clauses in contracts were strengthened to discourage departures.

Currently 9 in number, the neurologists in the group are said to be collegial and dedicated to the organization. Weekly business meetings are well attended, and each partner has an equal vote in the affairs of the practice. Managed care companies have validated the group by promptly credentialing each new member.

Texas Neurology has been innovative at BUMC in providing intraoperative monitoring for surgical cases. This service helps to ensure spinal cord function during delicate operations around the vertebral column. Outpatient intravenous infusions of gamma globulin and steroids are also available in their clinic. Members of the neurology department take an active role in Baylor teaching conferences and host a yearly seminar on current topics. To facilitate medical education conferences, a foundation has been established. Soon, a magnetic resonance imaging machine will open under the group's direction.

Dr. Tunell, the originator and leader of the group, said that "things have gone better than I would have imagined." He cited improved business functions, management expertise, and a high-level nursing staff as accomplishments of the group practice. "Strength in numbers" has been demonstrated in the functioning of the group. Dr. Tunell also pointed to advantages for patients; a "shared intellect" is brought to patient care. Hallway discussions among the partners serve as informal consultations. Steady, continuous call coverage is available (Gary Tunell, MD, interview, September 13, 2001).

HEALTHTEXAS PROVIDER NETWORK

Structured relationships of physicians with hospital systems or geographically dispersed group practices were a new concept toward the end of the 20th century. In the early 1990s, leaders of several groups of physicians staged a series of meetings that were destined to alter the norm. Representatives from MedProvider, Dallas Diagnostic Associates, Family Medical Center of Garland, and Inova met together on a number of occasions and shared ideas. Leaders from BHCS later joined the meetings to investigate their own interests. Motivations for discussions revolved around common needs of physicians: increasing contractual leverage in managed care discussions, gaining efficiencies in operations, and assisting in the recruitment and growth of the practices. This latter goal was of particular interest to the executives from Baylor, who sought an increase in their physician referral base.



Figure 11. Dr. Gary Tunell, founder of Texas Neurology.

Inova eventually broke off to explore its own interests, and the other three groups continued discussions that culminated in the formation of the HealthTexas Provider Network.

HealthTexas exists under a legal framework that requires its board to be composed of full-time physicians yet allows a “member,” BHCS, to control the budget. In a sense this ensures “checks and balances,” in that physicians must approve the workings and policies of HealthTexas, yet funding must come from the hospital system. Negotiations for the union of the hospital system and the physician practices took several years to complete. Legal contracts abounded but were unable to indemnify each party from harm or a disadvantaged position. Ultimately, the leaders of each group accepted the integrity and trustworthiness of the other and moved forward. The relationships between Boone Powell, Jr., Joel Allison, Gary Brock, Dr. Carl Couch, Dr. Lannie Hughes, and Dr. David Winter were pivotal.

Family Medical Center of Garland was the first group to sign up, followed by Dallas Diagnostic Associates and then MedProvider. Groups of physicians from Waxahachie, Terrell, Southlake, Rowlett, Plano, Irving, Mesquite, Grapevine, and Ennis have since joined.

HealthTexas has grown in numbers and sophistication. Total physicians now approach 360, dispersed in and around Dallas. The organization has demonstrated proficiency in practice management, contracting, recruitment, quality improvement, compliance programs, malpractice support, and physician retention. For the hospital system, HealthTexas has accomplished remarkable growth in aligned primary care physicians, with over 260 of the 360 employed physicians being newly recruited to practice and using the Baylor system. The physicians have benefited from the management expertise that has evolved.

HealthTexas’ commitment to quality health care delivery has been present from its inception, as reflected in its vision statement:

To demonstrate excellence in the delivery of accessible, cost-effective, quality health care and demonstrated customer satisfaction which delivers value to patients, payers, and the community in partnership with the Baylor Health Care System.

Physician-hospital organizations in the USA have generally not succeeded. HealthTexas stands out as an exception because of the quality of the physicians involved, the trusting partnership relationship with the hospital, and strong physician and administrative leadership. HealthTexas continues to evolve and has become an increasingly important part of BHCS.

MOTIVATIONS FOR GROUP PRACTICES

Are there unifying principles that drew physicians together into group practices at BUMC? A variety of motivations can be cited: call coverage, economic advantages, expansion opportunities, cultivation of new partners, and leverage in managed care negotiations. In every instance, leadership played an important role. The ability to communicate a vision and to balance the needs of the individuals with the needs of the group requires strong leadership skills. Kouzes and Posner summarized the fundamental characteristics of exemplary leadership as follows: leaders challenge the process, inspire a shared vision, enable others to

act, model the way, and encourage the heart (8). Examples of each of these traits were found in the leaders of group practices at BUMC.

Group practices brought physicians of high caliber together, allowing a sharing of ideas. Innovations in the delivery of health care resulted; for example, the outpatient delivery of dialysis and freestanding endoscopy clinics were pioneered by group practices. After-hours clinics, including weekend walk-in appointments, were developed by group practices. Sabbatical leaves, sponsorship at leadership and educational conferences, and the teaching and nurturing of younger physicians occur less frequently in small and single-physician practices.

THE FUTURE OF GROUP PRACTICES

The growth and popularity of group practices over the past several decades portend their further expansion in the future. They have benefited BUMC and the groups themselves by the addition of new physicians. Leadership and mentoring have helped to mold the careers of physicians, and they have served as a cohesive force for retention.

Group practice, however, is not inherently self-perpetuating and not always easy. Hospital systems that encourage and aid group practices are challenged to balance their support of other physicians on their medical staffs who may have disparate aspirations and priorities.

Subspecialization will challenge groups such as cardiology and orthopaedics. Disparities in call requirements and productivity could result in further splintering and may also curtail consolidation among the different fields of medicine.

Group practice does not fit every physician. Indeed, there are excellent physicians who will not fit into the group mold, just as there are brilliant musicians who cannot adapt into symphony orchestras. The loss of autonomy to the collective decision process of the group is not acceptable to some, though this relates less to matters of personal judgment in patient care than to future directions and policies of the group.

Groups themselves may succeed or fail depending upon their motivation. An early pioneer of group practices summarized the issue as follows: “A clinic started for the purpose of improving the quality of care [for patients] has a good chance of success; one begun with the wholly commercial purpose of making a better living for its members will surely die” (4).

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