

Medical Relations
Under
Workmen's Compensation
Revised

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INTRODUCTION

A new study of workmen's compensation cannot justify itself on the ground of lack of existing material dealing with this subject. Before compensation laws were enacted, the federal and state governments investigated the workings of such legislation in other countries and published voluminous reports, largely on institutions and methods of administration. Existing and past laws, commission and court decisions are amply presented in digests and discussions. Methods of adjusting and determining compensation for various injuries have been continuously and quite thoroughly treated. The complex systems of calculating and applying insurance rates is another phase on which a small army of actuaries, statisticians and inspectors are constantly engaged. Traumatic surgery and the technic of industrial medicine is another field occupied by its own specialists.

The one important phase that has remained comparatively neglected is the part played by the medical profession as a profession, as well as by the individual physician and surgeon in the institutions of compensation and in relations with such other factors as officials, carriers, employees and employers. Isolated phases have been frequently treated, and these have been freely cited where possible, but there have been only sporadic attempts to analyze the position and trace the history and present relations of the medical profession in the development and administration of compensation systems. In spite of increased recognition of the importance of that part of compensation which is awarded to the accident victim "in kind" through the services of physicians, students of this subject have been principally interested in other features.

This study aims to be at least a start in this field. It seeks to trace the part played by the medical profession in the evolution of compensation systems and to appraise its present position. Such subjects as the choice of physician, the character of service rendered under various conditions, the amount and forms of payment, and the different methods of organizing the medical service naturally fall within its scope.

The reactions on the medical profession of so far-reaching and comprehensive a system of medical care as that involved in compensation are an important part of such a study. In spite of some efforts in that direction, compensation practice has not been isolated from general practice. Developments in either of these fields quickly produce effects in the other. Contract practice, solicitation, methods of mass payment and treatment, fee-splitting, and the deteriorated medical service that accompanies these, cannot be quarantined within the compensation stockade. They affect in some degree every form of medical practice and therefore not only are the vital concern of the entire medical profession but, what is of even deeper significance, become the vital concern of the entire public, whose lives and health depend so closely on maintaining the highest possible standards of medical service.

The limits set for the study manifestly made it impossible to treat in any adequate way the special problems of individual states. Yet the very wide divergence not only in legislation and forms of administration but also in the customs, history and institutions that exist in the various states make such studies an absolutely necessary prelude to any effective program of professional action. Such local problems must be, and are now becoming, subjects of special study and analysis preliminary to action in several states. This work will have accomplished one of its main objectives if it assists and encourages such further investigation and action.

CHAPTER I

EVOLUTION OF SYSTEM

The laws creating workmen's compensation and the institutions by which it is administered grew out of certain industrial, economic and scientific developments and were formed according to the patterns of existing social institutions.

Compensation was the last stage, up to the present, of one line of evolution of the social legislation that resulted from the industrial revolution. The coming of the machine led to mass production and destroyed the relations of master and servant that had existed since the disappearance of chattel slavery. By the latter half of the eighteenth and the first of the nineteenth century the abuses growing out of the maladjustment of the new industrial relations and the old social institutions became so terrible as to demand legislation. Beginning with very mild factory regulations and slight restrictions on child labor this broad movement, early labeled as "humanitarian," became almost the dominating characteristic of legislative activity in all modern nations. That movement is a curious combination of conflicts and cooperation between greed and philanthropy, science and sentiment, and all the human emotions and economic phenomena of the period. It is still advancing under the impulsion of all these diverse forces. Its progress has seldom been planned. Most of its steps have been the result of many compromises. Each phase evolved largely independent of other parts of the same wide movement until clashes and conflicts compelled adjustments.

Workmen's compensation had its own peculiar lines of evolution. Out of the old personal relations of master and servant, custom, crystallized into the common law, had built up three basic principles or "defenses" to protect the employer against actions for damages growing out of accidents to his employees. The first of these was the "fellow-servant" doctrine, which absolved the employer from all responsibility if the injury was due to the actions of a fellow servant. The second was the "assumption of risk," which held that any person seeking employment assumed the risks of

the occupation. The third was the principle of "contributory negligence," which required the injured employee to prove that no oversight or carelessness of his had contributed to the happening of the accident.

All these defenses, against which we today almost instinctively revolt, were a very natural and logical outgrowth of the stage of small industry, with its little, largely permanent, group of employees, all known individually by the employer, who supervised their work, and to each other through long and close association. It is also probable, although this is not certain, that accidents in the hand tool stage were far less frequent, and it is quite undisputed that the value placed by public opinion on human life and welfare was much less than it is today.

When the great industry brought thousands of employees within a single organization so that the "fellow employee" responsible for an accident might be far removed from the sight and control of the person affected by his actions, when the risks became so complex and changed so frequently that the worker could not knowingly "assume" them and could not, therefore, know whether he was "contributing" to his own injury, these defenses became obsolete.¹

The helplessness of the worker to secure redress for injuries from an employer entrenched behind these three "common law defenses" became so flagrant an example of injustice produced by obsolete institutions as to compel a change. Growing humanitarian sentiment was revolted by the increasing number of dependent cripples thrown on charity by industry. The first attack was naturally directed at the destruction of these legal defenses, and this original legal approach has dominated the situation, with very significant and sometimes very harmful results up to the present time.

The entire object of these first moves was to restore the equality of employer and employee in the courts in order that the latter might have a better chance of securing *financial* recompense for his injuries. There was only the most incidental consideration of preventing the injuries, except through unrelated factory legislation (another legal remedy) and no thought of healing and restoring the worker's productive earning capacity.

1. National Industrial Conference Board: *Medical Care of Industrial Workers*, 1926, pp. 1-3.

Yet at the same time there was another and perhaps even more significant development taking place in the field of medical science which was ultimately to meet and profoundly influence this whole question of industrial injuries. The growth of bacteriology emphasized the importance of early medical attention, the dangers of infection and the possibilities of aseptic surgery. Developments in traumatic and orthopedic surgery were predicting new possibilities in the treatment of injuries. At this early stage none of these things came even within the fringe of consciousness of those who were formulating the institutions out of which was to come workmen's compensation.

The first effect of the removal of these defenses, and the consequent creation of a legal liability for damages on the part of the employer, who still had to be proved negligent to establish that liability, was a flood of litigation. Just how fast this flood rose is seen in a report of the increased number of decisions:²

"Under the heading Master and Servant in the United States Digest for 1857, in which an attempt was made to collect and digest the American decisions up to that time, there is but one paragraph that might apply to an injury claim. . . . In the United States Digest as brought down to 1870 there were but 65 paragraphs, or less than four pages, of decisions on masters' liability for injuries to servants, 31 of which decisions were on the fellow-servant question. Twenty-five years later when the Century Digest was published, collecting all the American decisions down to 1896, it contained 662 closely printed pages of small paragraphs arranged under 1,074 groups or headings, each paragraph digesting a point decided in a case involving master's liability for injury to servant. In the decennial edition of this Digest which collected and digested the decisions merely for the ten years 1896 to 1906, there are 1,086 closely printed pages of digest paragraphs. . . . The current volumes as published for the year ending March 1, 1912, contain over 200 such pages, so that for the ten years ending 1916 it will probably take a volume of more than 2,000 similar pages to digest the decisions under this division of the topic alone. . . ."

When there has been so great a lag between social changes and legal institutions, the new adjustment is apt to be extremely rapid. Between 1886 and 1917 nearly every important industrial state in this country

2. Berry, E. Sidney: *The Relation of Master and Servant under Common Law and Statutory Liability*, Hartford Insurance Lectures, 1913. p. 15.

modified or abrogated one or more of the common law defenses and introduced the system of legal liability of the employer. The result was that for about twenty years before the introduction of workmen's compensation, these states were operating under the liability system. This stage, although almost universally overlooked, or but casually mentioned in the discussions of the development of workmen's compensation, had very important effects on succeeding evolution. Perhaps the greatest of these effects was the introduction to the scene of an entirely new character that was henceforth to occupy the center of the stage—the insurance carrier. Employers involved in such a mass of litigation looked for some one on whom to unload the burden and found the insurance companies ready to assume the risk and the profits. This phase of the development came to us from England.

When the first workmen's compensation law was enacted in Germany, in 1884, sickness insurance had already established a pattern for insurance carriers in the form of a sort of mutual society managed jointly by employers and employees. The same plan was adopted with a few minor adaptations for compensation.³ When Great Britain modified the liability law in 1880 and substituted a compensation law in 1897, the employer was permitted to insure his liability with an insurance carrier.⁴

Such companies were therefore prepared to enter the United States the moment employer's liability was created by the abolition of the common law defenses. How quickly they occupied a commanding position in the field is told by one of their own spokesmen.⁵

" . . . In 1880 after the adoption of the Employers' Liability Act, the first form of insurance indemnity was offered (in England) by the newly formed Employers Liability Assurance Corporation of London. This company entered the States in 1886, making its headquarters in Boston, presumably since Massachusetts was about to pass an Act similar to the

3. For history and description of European systems prior to the enactment of compensation laws in United States, see Twenty-Fourth Annual Report of the Commissioner of Labor, 1909, "Workmen's Insurance and Compensation Systems in Europe."

4. Michelbacher, G. T., and Nial, Thomas M.: *Workmen's Compensation Insurance*, 1925, p. 91. See James Hamilton Boyd, "Workmen's Compensation," 1913, p. 13, for distinction between German and English type of compensation legislation as adopted in the United States.

5. Dennison, L. A. (Travelers' Insurance Company): "Historical Review—Liability and Compensation Insurance," Lectures before the Insurance Institute of Hartford, 1913, pp. 3-6.

English Act and the new company might find ready clients. The first American company to engage in this business was the Fidelity and Casualty Company of New York, followed almost immediately by The Travelers Insurance Company of Hartford.

"In 1887 the total amount of premiums from this insurance was \$203,132. This amount increased to \$8,328,834 in 1901, while during the past year—1912—they undoubtedly exceeded \$35,000,000.

"The two Hartford Companies underwriting this form of insurance—The Aetna Life and The Travelers—underwrite approximately one-third of this amount or \$12,000,000."

The profits of the insurance companies depended largely on their ability to defeat the intention of the advocates of the new laws to equalize the worker and employer before the courts. This was accomplished, first, by the use of clever adjusters, who sought to settle the cases out of court by sharp bargaining with the accident victim and, second, by the employment of able lawyers skilled in utilizing technicalities and delays to defeat the claim of employers' negligence and wear out the claimant for damages. The insurance companies took the place of the old common law defenses as the insuperable obstacle to any adequate recompense to the injured workers or their families. How effective they were in fulfilling this objective is shown by John R. Commons' description⁶ of what took place in Wisconsin:

"Employers of Wisconsin paid \$1,025,000 to liability insurance companies in 1911; scarcely \$300,000 of it reached the pockets of the employees or their dependents. Ten thousand industrial accidents occur in Wisconsin each year; 100 of these are fatal; the others cause disability of seven days or more. But scarcely 10 per cent of the injured received any share of the \$300,000."

That Wisconsin conditions were in no way peculiar is shown by a study of the operations of the insurance companies in other localities. The Minnesota Bureau of Labor, Industries and Commerce,⁷ after an investigation throughout the country reported:

"In 1905 the casualty companies doing business in New York State received in premiums from employers \$4,381,634 insuring them against liability towards employees for accidents. Now

6. Commons, John R.: *The Industrial Commission of Wisconsin, Its Origins and Methods*, Survey, Jan. 4, 1913, p. 3.

7. Bulletin 1, 1909, pp. 45-47. Michelbacher and Nial: *Workmen's Compensation Insurance*, p. 70. Bruere, Robert W.: *Compensation and Business Ethics*, Harper's Magazine, July, 1915, pp. 210-219.

of this sum 28 per cent went to pay the expenses of the insurance companies in defending suits or in profits, and only 32 per cent went to the workingman as a compensation for injuries received in cases which came up against these companies. . . .

"In the 10 years ending with 1907, \$82,732,705 were collected as premiums by the eight largest liability companies in the United States, and \$34,951,103 (or 42 per cent of the premiums) were paid out in losses to 1,619,607 injured workmen. . . .

"It is apparent from these figures that the liability companies are steadily reducing even the farcical compensation now being recovered by the workmen, and that the pittances at present obtained, in 2 per cent of the cases a little over \$400 and in the other 98 per cent less than \$20.00, are destined to diminish still further."

The defects of liability insurance became so flagrant that employers as well as employees demanded that the United States follow the example of Europe and advance to the compensation stage. Almost identical abuses in England had already brought about this advance.⁸

Public abhorrence led to a prejudice against the insurance companies which was reflected in frequent large verdicts for damages by juries. To be sure, this usually resulted only in further delay and appeals to higher courts, where such verdicts were frequently set aside. Such expensive litigation did greatly increase the cost of insurance, "so that whereas the companies used to write an employer's liability risk on the ordinary manufacturers risk as low as twenty-five cents on the pay roll—for the same risk during the liability period we were charging ten times that amount."⁹ In short, liability laws did succeed in collecting compensation from the employers, which was diverted from the pockets of the accident victims into the coffers of insurance companies.

8. "The result is that in England substantially all the small employers now insure in these private liability companies engaged in this ghastly traffic in life and limb purely for profit. The accident business never has been, and never can be, properly administered by an outside company intervening between employer and employee and finding its profit in preventing the victims from obtaining any or adequate relief. The insurance adjuster is the correlative of the ambulance chaser; both are, viewed in proper perspective, parasites—creators of strife and inhumanity; both should be eliminated before industrial accidents can be humanely and economically dealt with." Anderson, George W.: *Progress in Legislation Concerning Industrial Accidents*, *Annals of American Academy of Political and Social Science*, August, 1911, p. 215.

9. Fetzner Wade: *The History of Liability and Compensation Insurance*, *Bull. Insurance Club of Chicago*, February, 1920.

These high premiums naturally led the employers to favor compensation legislation as a cheaper and better solution. F. S. Schwedtman, chairman of the Committee on Employers Liability of the National Association of Manufacturers, reported, "I made an inquiry among twenty-five thousand American manufacturers a little more than a year ago. It indicated that more than ninety-five per cent of those answering were in favor of an equitable, automatic compensation system for injured workers and their dependents."¹⁰ Significant in the light of later developments is the fact that he urged the establishment of competitive state funds as carriers of such insurance, and that these should be so managed that "not less than seventy-five cents and preferably ninety cents out of every dollar paid into the insurance fund should be paid to injured workers or their dependents."

The insurance companies also realizing the approaching demise, from public indignation, increasing cost and consequent rise in premiums, of the goose from which such golden eggs had been gathered, began to look with favor on compensation legislation.¹¹

So general was the revolt against liability insurance that there was little objection to proposals to pass into the next stage of compensation. Many of the arguments offered in opposition were such futile and foolish deductions from generalized phrases as are always heard from those who try to rationalize their prejudices against any change.¹²

Up to this time all attention had been directed toward improving the strategic position of the worker in the fight for financial damages against the employer. The employer had met the removal of the common law defenses by the use of insurance companies. The effort to equalize the combatants having failed, the

10. Schwedtman, F. C.: Principles of Sound Employers' Liability Legislation, *Annals of American Academy of Political and Social Science*, July, 1911, pp. 202-204.

11. Dennison, L. A.: Historical Review—Liability and Compensation Insurance, pp. 10-11.

12. Nichols, Walter S.: An Argument Against Liability, *Annals of American Academy of Political and Social Science*, July, 1911, pp. 159-165. He says, "Our recent conceptions of an employer's liability are of foreign birth, the outgrowth of socialistic theories, which for years have been gradually permeating the state of Europe. . . . We are treading on dangerous ground in seeking to follow the footsteps of Europe regarding employers' liability. We are in danger of sacrificing the nation's birthright: the independent manhood and political equality of the individual citizen won by the founders of the Republic through the sufferings at Morristown and Valley Forge."

next step was to try to stop the fight. That was the object of workmen's compensation.

Neither the responsibility for accidental injuries nor the damages to be paid was henceforth to be decided by the outcome of a legal battle. The responsibility was to be assumed by industry as a whole and the amount of the damages or compensation was to be fixed by law and apportioned by impartial administrators without court action. But substitution of the word "compensation" for "damages" did not alter the fact that the objective was still the proper distribution of a sum of money as a recompense for injury.¹³

The change to the compensation system proved again that when a set of institutions has been permitted to lag far behind their environment the result is a hasty, ill considered leap:¹⁴

"Having stood by for years, while all of the other great industrial countries were gradually developing their plans of caring for the victims of industrial accidents, the American states, in the second decade of the twentieth century, apparently at last convinced of the practicability of foreign experiments, tried to see which could be the first to write upon its statute books a law which had for its purpose the compensation of industrial cripples. In no single decade, in any part of the world, had there been such a complete turn to a new form of social legislation as was experienced during the period from 1910 to 1920, when state after state substituted for its employers' liability system a type of legislation in which the first word in the title was 'workmen's,' while the second word suggested a payment, rather than a quibbling over the question of liability."

The character and results of such legislation can be understood only after an analysis of the interests responsible for its enactment and administration. Three of these interests have already been considered—employers, employees and insurance companies. A fourth character now enters the scene—the social workers, composed of philanthropists, economists, sociologists, directors and officials of a wide variety of philanthropic and social research organizations. These workers were an outgrowth of the extension of the humanitarian movement and of an effort to direct its expressions in a scientific and efficient manner.

13. Hulvey, Charles N., and Wandel, William H.: *Workmen's Compensation and Auto Liability in Virginia*, 1930, p. 3.

14. Bowers, Edison L.: *Is It Safe to Work?* 1930, p. 17

It is obviously impossible to make any reliable statistical appraisal of the relative strength and influence of these forces. We can, however, approximate such an appraisal by a study of the relative strength of the representatives of each such interest in the early stages of compensation legislation.

In December, 1916, a conference on social insurance was called at Washington by the International Association of Industrial Accident Boards and Commissions, and a list of those who attended with their affiliations is attached to the report of the proceedings. Of those present whose affiliations can be definitely determined, fifty-five were officials of existing commissions, labor departments, or other state or federal bodies concerned with the administration of labor legislation. The second largest body was composed of the representatives of insurance companies and numbered fifty. In the third place come forty-two representatives of employers and next thirty-three who can be classified as social workers, being persons who were occupied with the study of social problems, with propaganda for legislative reform or with the care of poverty. There were but four representatives of organized labor and fourteen physicians present, and only one of the latter presented credentials from a medical organization. Nearly all the others were connected with insurance companies or were public health officials or industrial physicians in the employ of large corporations. Moreover, none of these took any prominent part in the discussions or appeared to exercise any great influence on decisions.

These facts would seem to justify the conclusion that neither labor nor organized medicine had much influence or interest in the formative stages of compensation legislation.

To determine the effects of these various interests on the laws and administration of compensation, one should know their aims and objects. Unfortunately, this is difficult to determine except as it is revealed in their statements and attitudes. Moreover, they had not always clearly thought out their own programs or determined their real interests and were often reluctant to announce their intentions or reveal their tactics. Nevertheless, a study of these statements and the attitude of representatives of the various interests toward legislation and administration and of the effects of

actions and tendencies on such interests makes it possible to draw the following conclusions:

Social workers were largely concerned with the relief of poverty. Their work had brought them in close contact with the economic sufferings of the industrially injured. They had seen and resented the injustices of liability insurance. They sought to simplify legal procedure and to strengthen the efforts of the workers to obtain adequate compensation. They have generally been in opposition to the insurance companies, but sometimes cooperated with them to the extent of compromising their own programs to secure support for legislation. The antagonism grew sharp when insurance companies tried to increase their own income at the expense of adequate compensation, for which the social workers always strived. They usually favored the establishment of state insurance funds. How completely they overlooked the medical phase is shown not only by their actions but by the definite statement made many years later by one of their foremost representatives,¹⁵ who was most active in the movement for workmen's compensation:

"I remember on the first occasion when a workmen's compensation law was pending in the state of Indiana, being very much surprised when it was suggested that the physicians ought to be consulted. I said to myself, 'What interest has the physician in the workmen's compensation bill?' That was as unintelligent as I was at that time. I thought, 'Why should they be interested?' They were not interested, generally speaking."

The insurance companies were in every way the best equipped to influence legislation. They had able attorneys to formulate, and skilled lobbyists to press, the laws they desired. Behind these were the largest compact resources of cash and specialized information possessed by any of the interests involved. They were the only ones with any broad experience directly applicable to the situation. Their practical monopoly of the liability business made them the natural heirs to the insurance side of any system adopted.

Against their influence was the fact that the demand for compensation was largely a revolt against the practices of the insurance companies under liability. It was to abolish these abuses that the compensation system

15. Lapp, John A.: *A Social View of Medicine*, Wisconsin M. J. 30: 477 (June) 1931.

was introduced. Yet when that system was introduced these companies were able to control the most important phase of its administration except in a few states and to set the stamp of their methods on the operation of the insurance phase even in some states from which they were excluded. The insurance companies, in defense of the interest of employers, have usually sought to restrict benefits. A liberal policy with high premiums makes selling more difficult and also complicates administration by increasing the size of the financial units involved. They paid little attention to the medical problem at first and have always approached it primarily from the point of view of its effect on cash compensation.

While many companies have come to recognize the value of prompt and adequate medical care in reducing time lost and consequently the amount of compensation, they were principally interested in such control of the physicians and surgeons as assured favorable medical testimony in determining cash payments. This attitude was inherited from the liability stage, which made no provision for medical aid and when the physician was of interest to the insurance companies only as an expert witness. It was strengthened by the fact that a majority of the early compensation acts provided for only the most perfunctory medical service, and so the whole medical side was at first looked on as purely incidental.¹⁶

A number of western railroads and some coal, mining and lumber companies and a few other industries had established plant medical systems under liability. These were quickly adjusted to the compensation system and in some localities became of great importance in the operation of that system.

Employers usually sought to limit compensation benefits. Experience under the liability plan led them to insist on retaining the right of self-insurance or to form their own mutual companies. Their fear of state activities, on the other hand, caused them to oppose state insurance funds. They commonly opposed any stringent factory legislation required to prevent accidents. Their influence also tended to restrict funds for administration to a point that has hampered statistical

16. Merrels, Frederick B.: *Compensation Administration in Liability and Compensation Insurance*, Lectures Before Insurance Institute of Hartford, 1913.

work, accident prevention and efficient operation. They shared the general attitude of indifference to the medical side and seem to have had little to do with determining such medical features as were included. An exception is found in a number of states, mostly in the West, where a form of medical care based on payroll check-offs had already been established. The employers succeeded in having these arrangements perpetuated in the compensation laws and thereby laid the foundation for important later developments. The employing interest also pressed for the right to control the choice of physician, which right they have almost universally delegated to the insurance companies.

In spite of the tradition that workmen's compensation came in response to demands of labor, an examination of the labor journals, convention proceedings and other organs for the expression of labor opinion shows little active interest. To be sure, many labor organizations adopted resolutions favoring compensation, which in some cases at least were prepared and urged by social workers, but such adoption appears to have been rather perfunctory and not backed by any further action. Labor favored liberal compensation, and the result measures the ineffectiveness of its influence. Liability experience left labor hostile to the insurance companies, and the organized workers of Ohio are commonly credited with making that state the pioneer and leader in establishing an exclusive state fund. Labor organizations in other states have campaigned actively for state funds. Whenever the question has arisen, the employees have always urged that the injured worker be given the right to choose his own physician, and they were primarily responsible for several steps in the direction of greater freedom of choice.¹⁷

During this whole formative period the physicians and the workers, who were the parties most concerned and whose condition was to be most deeply affected by the operation of the compensation system, seem to have been largely indifferent to the actions being taken and blind to their possible effects. The one exception is the Report of the Judicial Council of the American Medical Association in 1915. But since this did not seem to have any effect in arousing the body of the

17. For a full discussion of the attitude of labor, see Durand Halsey Van Doren; *Workmen's Compensation and Insurance*, 1918, pp. 238-264. For attitude in Idaho, see *First Report of Industrial Board*, 1918, pp. 12 et seq.

profession, its full consideration is deferred at this point. The various state medical societies seem to have concerned themselves but little with what was happening. In Connecticut, for example, the Report of the State Commission on Compensation for Industrial Accidents, 1912, page 1, says: "They have expressions of opinion from representatives of all interests, including especially labor unions and workmen generally, also from the Manufacturers Association of the State of Connecticut and from individual employers of labor." But there is no mention of medical representation, and the report, in outlining a proposed compensation law, makes no mention of medical care. Yet Connecticut was the first state to give unlimited medical care.

A Report of the Board of Trustees of the State Medical Society of Iowa¹⁸ describes the medical indifference at the time of enactment and subsequently as follows:

"The profession of the state feels that our compensation law has been framed to protect the laboring man and at the same time to safeguard the interests of industry, but that the rights of the doctor, who practically is an important third in industrial injury cases, have been ignored. It is not strange that this should be so, since the doctor alone, of the interested parties, was not represented, was not consulted when the law was framed. The physician has been vehement in his denunciation of the law, but it is safe to assume that, when the law is again amended, he will again be conspicuous by his lack of representation and that little attempt will be made to adjust his grievances. He may continue to nurse his individual grouch in silence, or he may air his woes at length at meetings of his county society; in either event his protest will not penetrate to the legislative halls, and once more the question of just compensation for the physician will receive but scant consideration from industrial, insurance, or labor interests—unless the doctor learns that as a medical unit he is all powerful, but as an individual he means nothing to our legislators."

If the state societies were inactive, the local county organizations, through which any really effective political pressure would necessarily have been brought, seem to have been almost wholly unconscious of what was happening. There are some very evident reasons for this lack of interest at this time. Medical service had no place in the liability system and, in the beginning,

18. Report of Board of Trustees, Iowa State Medical Society, J. Iowa State M. Soc., July, 1927, p. 255.

was almost ignored under compensation. The very name "compensation" focused attention on the financial features, and all the early discussion followed this line.

It would be possible to pile up almost any amount of additional evidence as to the disregard of the medical profession in the formative stage of compensation legislation.¹⁹ Henry B. Bole, of the Standard Accident Insurance Company of Detroit, in an address before the Fire Insurance Club of Chicago, characteristically remarks: "I am assuming that, in the working out of the workmen's compensation plan, steps will be taken to take care of the incidental questions involved, also including medical and hospital services." Finally, when a conference of commissions was called in Chicago in 1910 to discuss compensation for accidents, thirteen subjects of possible interest were listed as "topics of discussion" but no mention was made of medical service.²⁰

What was the character of the legislation that emerged in such a flood out of such a welter of conflicting forces during the first years of the second decade of this century? In the first place it was so diverse that any common characterization is difficult. The opportunity for experiment offered by forty-eight states, and the federal jurisdictions was thoroughly utilized so far as differences are concerned, four states still retaining the old liability system. Little real use has been made of the knowledge that might be gained by comparative study of that experience. In spite of sporadic efforts to secure some sort of uniformity, each state has shown a tendency to proceed on its own course with little regard for lessons that might be learned from other states.

We have seen that liability and compensation laws may be looked on as successive attempts to equalize the legal conflict between employer and employee in order to assure the worker or his dependents adequate compensation for injuries received in the course of his

19. See, for example, National Industrial Conference Board, "The Workmen's Compensation Problem in New York State," 1927, p. 117; and Winfield W. Greene: "Workmen's Compensation in the United States," 1924, p. 8, where the various interests concerned in the establishment and operation of compensation are described with no mention of physicians; Texas State Journal of Medicine, June, 1930, p. 108; Journal Kansas Medical Society, March, 1927, p. 88 and January, 1931, p. 22; Minnesota Medicine, January, 1925, p. 37.

20. Proceedings of Conference of Commissions on Compensation for Industrial Accidents, Chicago, November, 1910, *passim*. However, there was an incidental discussion of some medical problems, pp. 135-140.

employment. When the first compensation legislation was enacted, it soon became evident that the employers and the insurance companies had again defeated this objective, at least so far as adequate payment is concerned. Even such an ardent advocate of compensation legislation as I. N. Rubinow²¹ says:

"One is almost tempted to doubt whether the compensation acts really present as great an improvement over the old liability system as we are ready to assume. It is forgotten that even under the old laws liability insurance tended to establish some rough system of compensation; i. e., in order to avoid costly litigation and large verdicts, casualty companies were usually anxious to settle as many claims as possible by payments of small amounts. Do the workingmen really get more now"?

Twenty years of observation of the working of compensation laws have not yet converted the unions of railroad employees to a belief that they would be better off under a federal compensation law than they are under the old liability laws. W. N. Doak, Secretary of Labor, and a member of a railroad union, in a recent address before the International Association of Industrial Accident Boards and Commissions, lists eleven reasons for this preference for the liability status.²² The most important reasons are:

"The compensation laws heretofore proposed have provided schedules that were beggarly low in cases of death where no heirs were left except children, thereby reducing the liability of the carriers, which we believe is fundamentally wrong."

"Compensation, generally speaking, places an estimate on human life and limb so low that one wonders how men who know life and its hardships can favor it as against liability."

No sooner were the compensation laws enacted than there began a rapid process of amendment, which still continues and the course of which has been determined by the conflict of the same interests that were involved in the original legislation. These interests constantly change in form and relative strength. In the course of this conflict, certain theories of compensation have been developed by courts, legislators, commissions or other bodies, and because these theories are the expression of

21. Rubinow, I. N.: *American Labor Legislation Review*, June, 1913, p. 281.

22. *Bulletin United States Bureau of Labor Statistics*, No. 564, April, 1932, pp. 53-61. This also includes criticisms of this position by several delegates.

intellectual and institutional patterns they have had considerable influence in determining legislation and administration. They indicate the objectives of those who formed the laws and therefore afford a measure of the success attained in reaching those objectives and also a suggestion of probable developments if those theories continue to guide legislation and administration.

The orthodox legal theories are stated by a recognized authority as follows:²³

"One school still regards the new system as providing a novel but limited remedy in tort. That is, it assumes that the injured worker, under a simplified procedure, is to be indemnified in a limited amount for a new form of misconduct imputed by law to his employer. Compensation in that view of the matter is intended, like the old liability statutes, to afford redress for a private wrong and is therefore a new regulation of private rights. The other school regards workmen's compensation as the writing by the state of a limited insurance policy, against work injury, into the labor contract. It vindicates this contractual obligation upon the generally recognized fact that under the conditions of modern industry, generally speaking, the circumstances out of which work injuries arise are only to a limited extent within the control of the parties and have therefore but a restricted relation to their conduct. The risk of injury is held to inhere in the manner in which the work of the world is now done. Accident originates, broadly speaking, in the environment of production rather than in the conduct of the person involved. Thus responsibility for occupational injury becomes social rather than individual."

A more frequently used theory, which sets forth the social attitude and is the base of much discussion and action in administration, deals with the principles on which the costs of compensation are to be distributed:²⁴

"Compensation to the injured workman is based upon the theory that the consumer of economic goods should bear all the expenses incurred in the production of such goods. Among these expenses must be included the pecuniary losses from deaths and injuries, as well as occupational diseases contracted in the regular course of production. Wages lost, medical attendance and burial expenses, in case of accidental injury or death, are all losses which should be considered as a

23. National Industrial Conference Board, "Workmen's Compensation Act in the United States—The Legal Phase," April, 1917, p. 7. Research Report No. 1.

24. Goldberg, Rosamond W.: Occupational Diseases in Relation to Compensation and Health Insurance, 1931, p. 141. See Brown, Harry Gunnison: The Economics of Taxation, 1924, pp. 162-163, for statement of theory that worker pays entire cost.

part of the expense of production. In order to avoid this, the expense of work-accidents should seemingly be considered as a part of the production costs. By placing upon the employer the partial cost of work accidents and, in some instances, of occupational diseases as well, a method of regulation is exercised which functions to check in part at least the industrial accident and disease rates."

A corollary to this method has so wide a bearing on questions of benefits, methods of carrying insurance and other important phases that it is worth while to include its statement by a well known authority²⁵ on compensation:

"The guiding principle for the determination of compensation benefits is that of least social cost. That scale of benefits is to be preferred which most conduces to the prevention of industrial injuries, which best promotes the removal of disability when injury has occurred and which so distributes the residual economic loss as to be least felt by individuals and by the community at large. So defined, the canon of least social cost requires, on the one hand, the fullest possible medical relief and, on the other hand, indemnity commensurate with wage loss."

Since compensation payments are enforced by law according to a definite schedule, it was early suggested that they were in the nature of a tax. Some rather important conclusions followed from this point of view which was sustained by the United States Supreme Court in a case appealed from the state of Washington.²⁶

A few observers in the early stages of workmen's compensation recognized that a wrong start had been made in placing all emphasis on cash compensation to the neglect of medical problems, but they were unable to change the course of evolution. In an address before the fourth annual meeting of the International Association of Industrial Accident Boards and Commissions in 1919, Edward F. McSweeney,²⁷ former member of the Massachusetts Industrial Accident Board said:

"It was also recognized by the committees which studied the subject before the enactment of these laws in the various states

25. Downey, E. H.: *Workmen's Compensation*, 1924, p. 35. See also Witte, Edwin E.: *The Theory of Workmen's Compensation*, *American Labor Legislation Review*, December, 1930, pp. 414-415.

26. 37 Supreme Court, 267. See also Boyd, James Hamilton: *A Treatise on the Law of Compensation for Injuries to Workmen*, 1913, p. 127.

27. Bulletin U. S. Bureau of Labor Statistics, No. 248, p. 283.

that the larger part of their administration would be medical and not legal. Yet in actual practice the legal and technical aspects overshadow the medical, to the detriment of all concerned. The nature of the work urgently demands the services of one or more reputable and skilled medical officers on every board. After appointment, medical officers should have stability of tenure of office."

In recent years a quite different idea of the purposes of workmen's compensation has come to be recognized. This change, which indicates a greatly altered attitude toward the whole problem, is set forth as follows by the Connecticut Board of Compensation Commissioners:²⁸

"To the public generally it sometimes appears that the primary purpose of the statute is to pay money to an injured workman or his dependents. This is, of course, a matter of great importance, but the primary purpose of the statute is not to pay money to an injured workman or his dependents. The real object of a workmen's compensation law is to diminish accidents. Next in importance to that is the prompt providing of skilled and competent medical, surgical and hospital services, and the disability payments figuring more prominently in the public view are really third in the purpose of compensation statutes or in the benefit which they confer upon the public generally."

Just how complete this change of attitude now is can be seen from a quotation from the report of the Industrial Survey Commission of New York (Legislative Doc. No. 87, 1928), of which it is interesting to note no physician was a member. The Commission says, (pp. 60-61):

"No question is of more importance in the administration of the compensation law than the question of proper and adequate medical and surgical treatment of injured workmen, and the proper determination by medical examination of their injuries. As time has passed since the enactment of the law, the importance of the medical question has been more and more emphasized and recognized. . . .

"In the minds of many, the provisions requiring the employer to furnish all necessary medical care and treatment are among the most important in the law. It has well been said that the crowning glory of the compensation system is its medical service. . . .

"Question arises, however, if the medical question is of such overwhelming importance in the administration of the com-

28. Report for 1927-1928, p. 9.

pensation law, why have not the medical men been afforded the opportunity and, in fact, charged with a certain responsibility, for aiding in the administration of the law. Your commission is informed that the medical societies of the state stand ready and willing to cooperate with the public authorities. Some effective form of cooperation of a dignified character, and representative of all forms of medical practice, cannot but be beneficial to the department and the administration of the law, and it should go a long way toward reassuring the medical practitioner that his voice will be heard and his problems considered."

CHAPTER II

PREVENTION OF ACCIDENTS

It should be evident that early compensation legislation approached the problem of industrial accidents almost exclusively from the legal and financial side. Efforts were directed toward overcoming the legal advantage of the employer over the employee, which arose out of the development of the great mechanized industry and mass production, and to insure to the injured worker adequate cash compensation for the destruction of his productive capacity. The employee was not considered primarily as a human being but as a factor in production. Suggestive of this often subconscious, but perhaps all the more effective, attitude is the analogy so frequently used by advocates of compensation laws, that since industry assumed the expense of repairing a machine broken in the process of production it should do no less for the injured human productive factor. This analogy was never pushed to the logical conclusion that effort should be primarily directed to the repair of the human producer; i. e., to medical care. It was assumed that financial payments sufficient to keep him alive during his unproductive period were the principal object.

It was urged as an argument for compensation legislation that, if payments were certain and directly proportionate to the severity of accidents, such legislation would prevent accidents. In its early stage there were great expectations as to the reduction in accidents to be brought about through compensation. The Report of the Employers Liability Commission of Iowa (1912), in urging the enactment of a compensation law, said: (p. 18)

"If the General Assembly will provide efficient and adequate means for the enforcement of laws relating to accident prevention, injuries to employees in this state can be reduced, in a very conservative estimate, 50 per cent, and thereby very materially reduce the cost of any new system for compensation."

Other predictions were even more optimistic. Apparently no one thought to look at German experience,

although the merits of the German law were often cited. If the records had been consulted it would have been discovered that, in the twenty-five years during which the German law had been in operation before the enactment of the first American law, accidents had increased in Germany from 27.42 per thousand employed to 52.83.²⁹

For a short period the optimistic expectations as to the reduction of accidents under the American compensation system seemed to be justified. Certain industries, particularly the steel mills and some of the larger machine industries, entered on extensive safety campaigns that produced most gratifying reductions in their accident rates. The National Safety Council was formed as a center of expert information and propaganda for prevention. All the paraphernalia of American advertising ballyhoo was called on to arouse the interest and enthusiasm of employers and employees in a great crusade against accidents. Slogans, posters, contests, prizes, lectures and a veritable flood of printed matter were used to whip up sentiment and enthusiasm for safety programs. "I think that the safety movement on this continent is suffering from some of the things religion is suffering from," said R. B. Morley, general manager of the Industrial Accident Prevention Associations, "and that is a certain type of mushiness."³⁰

The fact that "safety campaigns" have been so largely confused with the advertising campaigns of insurance companies may account in some degree for their character. The supposed objective of reducing the human injuries has been inevitably obscured by such other objectives as reducing premiums and compensation, and increasing insurance business. These objectives may seem to have much in common, but there are important points where they diverge widely.

For a few years, available statistics seemed to indicate a decline in the accident ratio. Before trying to draw any further conclusions as to the number and tendencies of accidents, there should be a prefatory word of warning as to the statistical foundations of any such conclusions. It was confidently expected that the

29. Villard, H. S., and Sherman, P. T.: *German Experience in Accident Prevention*, Workmen's Compensation Publicity Bureau, January, 1914, p. 3.

30. Proceedings International Association Accident Boards and Commissions, October, 1931. Bulletin 564, United States Bureau of Labor Statistics, p. 221.

operation of workmen's compensation would yield adequate and accurate statistics of accidents. After fifteen years of operation, James J. Davis,³¹ then Secretary of Labor, said, "We have no agency whatever entitled to answer with authority the question, 'Are accidents on the increase or are they declining?'"

One is met at the beginning, and will be hampered in discussion of all phases of compensation, by a lack of any precise definition of an accident. The thing to be defined is indefinite and the subject matter to be defined is constantly viewed from conflicting attitudes, which results in a confusion of legal, medical and economic terms. The legal definition is concerned with the character of the happening and is expressed in the standard British decision as "an unlooked for mishap or an untoward event which is not expected or designed."³² The indefiniteness of this definition is apparent at once and especially when viewed in the light of later decisions extending its scope to thermal, photic, chemical, electrical and bacterial injuries and even to occupational disease.³³ Manifestly it is valueless for statistical purposes. The economic definition would cover only those accidents involving a financial loss and when adopted by commissions and others as a statistical base has sometimes been further restricted as applying only to those accidents for which compensation has been paid. Both of these definitions conflict with the medical attitude, which considers the effect on human beings produced by a trauma or injury. It will be seen later how these differing definitions have confused not only statistics but a number of other important legal and administrative phases of compensation.

This basic confusion is further confounded by the way in which such statistics are collected and analyzed. The principal agency for their collection is the employers, and the immediate use to which they are

31. For discussion of character of accident statistics, including address quoted, see Bulletins 428 and 301, United States Bureau of Labor Statistics, pp. 57-64; also, Downey, E. H.: *Workmen's Compensation*, 1924, pp. 16 and 137; National Industrial Conference Board, "The Workmen's Compensation Problem in New York State," 1927, pp. 7-8, and "Report of the Committee on Statistics and Compensation Cost," of the International Association of Industrial Accident Boards and Commissions, Bulletin 248, U. S. Bureau of Labor Statistics, 1919, pp. 98-116.

32. *Fenton v. Thorley and Co.*, quoted in Pease, J. G.: *An English Workman's Remedies for Injuries Received in the Course of his Employment*, Columbia Law Review, June, 1915, pp. 509-523.

33. Sappington, C. O.: *Analyzing Accident Terminology*, National Safety News, July, 1931, p. 29.

usually put is to determine the amount of compensation premiums to be collected. The employer, therefore, has a strong cash incentive to keep the number of reported accidents low. Against this must be balanced the eagerness of the employee to report his accidents in order to secure compensation; but this motive applies only when the injury is sufficiently serious to make his employment impossible. Consequently, most of the highly emotional competitive "safety contests" count only "time-lost" accidents, which leads to conditions such as are described by J. Dewey Dorsett³⁴ of the Industrial Commission of North Carolina:

"The Aluminum Company of America carries on a billion-dollar operation in the state of North Carolina and some time ago it had a big celebration and invited most of the state officials and the higher-ups in the state to attend. Two thousand people attended the affair to celebrate the fact that the plant had operated two years without a lost-time accident.

"About six or seven months following that celebration it was necessary, on account of the depression, to lay off some employees. We began to get requests at the industrial commission for hearings, and I went over to conduct them. I found we had men who had actually lost arms and broken legs, men who had actually suffered hernias, and they convinced me, as hard as I am to be convinced along that line, that they ought to be paid for them. We found that, after a man's hand had been amputated at the wrist, he would be put to work the next day painting a crosstie, so the plant had no lost-time accidents.

"I think that there is a danger of stressing too much the idea of no lost-time accidents, particularly if the plant will not put its cards on the table face up."

The various compensation commissions are another important source of accident statistics. The character of the material derived from this source is the despair of statisticians:³⁵

"About twenty compensation boards issue annual or biennial reports which contain the number of injuries compensated in their respective jurisdictions. But of these reports some are for calendar, others for fiscal, years; some include and others exclude occupational disease, some exclude establishments which employ fewer than four, six or ten persons; some purport to give all reportable injuries, others omit disabilities of less than

34. Discussion at Meeting of International Association of Industrial Accident Boards and Commissions, 1931, Bulletin 564, United States Bureau of Labor Statistics, p. 199.

35. Downey, E. H.: *Workmen's Compensation*, 1924, p. 16, note.

one week, ten days or two weeks. The classification of injuries in respect of severity is equally diverse. Any attempt at combination or comparison of the published statistics is well-nigh hopeless."

Bearing in mind these defects, which are too frequently overlooked in the use of accident statistics, it would seem that the effort at reduction of industrial accidents reached its maximum effects within a few years and thereafter accidents began steadily to increase, at least in severity and probably in number.³⁶

The reasons given for this probable increase (which, it must be remembered, is still denied by some observers) are as diverse as the character of the statistics. The American Emergency Council³⁷ believes it to be an inevitable result of the growing intensity, speed and mechanization of modern industry, and notes that the accident rate follows cyclic fluctuations, being higher in times of prosperity, when more unskilled and inefficient workers are employed under speeded up production.

Some observers hold that insurance against accidents may tend to encourage an indifference to the accident rate. Dr. E. W. Williamson³⁸ of the Department of Clinical Research of the American College of Surgeons says of some employers:

"After securing insurance their sense of responsibility ceases—the attitude toward compensation insurance is the same as towards fire or life insurance—that is, they are insured and in case disaster occurs the insurance company pays the damages. This class assumes no responsibility in accident prevention or in cooperating with the carrier in authorizing prompt and competent medical service to injured employees. Even the explanation to the employer that the amount of his premium is based on the cost of carrying his insurance seems to have little influence in increasing his interest in the problem."

36. On this increase see: American Labor Legislation Review, June, 1924, p. 180; Report Workmen's Compensation Bureau of North Dakota, 1930, p. 6; Monthly Labor Review, May, 1932, p. 1086; Report State Industrial Commission of Oklahoma, 1927, p. 5; American Engineering Council, "Safety and Production," 1928, pp. 2-5; Wilcox, F. M.: "Medical Care and Costs," Safety Engineering, Feb. and March, 1930; Bulletin 511, U. S. Bureau of Labor Statistics, April, 1930, pp. 74-82; Handbook of Labor Statistics, 1931, Bulletin 541, U. S. Bureau of Labor Statistics, p. 299, et. seq.; National Industrial Conference Board, "Workmen's Compensation in New York State," 1927, pp. 179-195.

37. Safety and Production, 1928, p. 2; See also Downey, E. H.: Workmen's Compensation, pp. 2-3; Harrington, Daniel: Effects of the Mechanization of the Coal-Mining Industry upon the Frequency and Severity of Accidents, Bulletin 536, U. S. Bureau of Labor Statistics, April, 1931, pp. 183-194.

38. Report of Symposium and Surveys, 1929, p. 48.

The investigation of the National Industrial Conference Board led to the same conclusions.³⁹ Edison L. Bowers, in common with several other students, holds that the low rate of compensation makes it at least appear cheaper to pay insurance premiums than to maintain adequate safety precautions. He⁴⁰ says:

"The principal reason why more money is not spent for injury prevention is that the employer is not compelled to do it. If, in a given concern in a given period, there are lost 3 lives, 6 arms, 2 legs and 10 fingers, the cost to the employer, as he incorrectly sees it, is not in excess of the amount of the benefits paid to the injured persons, plus the operating costs of insurance. Bluntly, it may be cheaper to pay \$2,000 for an arm than to prevent its loss. . . .

"The injury expense account is relatively small because injury benefits are small. Injury benefits are small because human beings are not rated at their true economic value. If industry had to pay the actual loss caused by industrial injuries, the safety problem would loom larger in the average company's affairs; the tactics employed in preventing injuries would correspond to the new importance of the enterprise. The program for safety would be changed with the same regularity and effectiveness which characterize the commercial advertisements blazoned on thousands of bill-boards. It would not only be a question of producing goods and selling them at a profit, but of producing goods with an injury record sufficiently low to make profits possible."

Up to the present time the safety movement has been largely dominated by the mechanical, legal, financial and supervisory point of view. It sought first to make the machine and the processes of production less dangerous by guards and other safety devices and by altering the processes of production. This was supplemented by legal regulations and then by factory orders to be enforced by a combination of discipline, education and propaganda. All these measures were reinforced by the rather weak financial argument of expense to the employer. This expense is varied according to the accident rate by "schedule" and "experience" rating of compensation insurance. Very little attention was given to the human being who was being injured and

39. *Workmen's Compensation Problem in New York State, 1927*, p. 7.

40. *Is it Safe to Work? 1930*, p. 163. See also Woodbury, Robert Morse: *Workers Health and Safety: A Statistical Program, 1927*, p. 24. On effects of schedule rating see National Industrial Conference Board: *Workmen's Compensation Problem in New York State, 1927*, p. 144; on effect of shop rules see Childs, L. H.: *Recent Compensation Developments*, *J. Michigan State M. Soc.*, June, 1930, p. 447.

whose actions, in a majority of cases were, in some way, a causative factor of the accident. Recent more careful analyses have revealed that accidents, even in modern industry, are still largely personal and individual and arise out of the physical and mental weaknesses and defects of the human factor in industry.⁴¹

"Safely to perform their work," says E. H. Downey,⁴² "the operatives of a modern mill, mine or railway should think consistently in those mechanical terms in which the industrial process runs. They should respond automatically to the most varied mechanical exigencies and should be as insensible to fatigue and as invariable in behavior as the machines they operate. Human nature, inherited from uncounted generations that knew not the machine, does not possess these attributes in anything like the requisite degree. The common man is neither an automaton nor an animated slide rule. His movements fall into a natural rhythm, indeed, but the beat is both less rapid and more irregular than the motions of machines, with the consequence that he fails to remove his hand before the die descends or allows himself to be struck by the traveling crane. It requires an appreciable time for the red light or the warning gong to penetrate his consciousness, and his response is apt to be tardy or in the wrong direction. Fatigue, also, overcomes him, slowing his movements, lengthening his reaction time and diminishing his muscular accuracy, thereby treble enhancing his liability to accident."

Because this change in point of view so greatly affects medical relations of compensation, it deserves further attention. The new attitude is summed up by Dr. C. O. Sappington,⁴³ director, Industrial Health Division, National Safety Council, as follows:

"If we take the trouble to study closely the evolution of accident prevention, there are two deductions which seem to be plain:

"1. In former years, the greatest emphasis was placed on the care and maintenance of equipment.

"2. The tendency at present seems to be to shift the emphasis from machines to men. The present trend also indicates that

41. International Labor Office, *Encyclopedia of Hygiene, "Pathology and Social Welfare,"* vol. 1, p. 1930.

42. *Workmen's Compensation, 1924,* p. 7.

43. *National Safety News,* January, 1931.

the part which human beings play in accidents will be more emphasized in the future."

Shifting of attention from machines and money to human beings promises not only to transform the whole technic of accident prevention but also to change fundamentally the position of the physician at the very beginning of the compensation problem and to change it in accordance with a trend that was already becoming dominant in other stages of the treatment of that problem.⁴⁴

If, in spite of mass production, accidents are still largely individual, effective prevention must also be fundamentally individual and personal. Without in the least belittling mechanical guarding, factory legislation and safety regulation, it is now evident that such generalized social action in the prevention of accidents, like the analogous social health measures, while of great importance, leaves a wide field of individual treatment untouched, in which the results of the application of mass treatment are disappointing. For instance, it was early discovered that new employees are much more subject to accidents than old. An analysis of the accident figures of the iron and steel trades by the United States Department of Labor showed that the annual accident frequency for employees of less than six months' experience was almost three times that of those with from three to five years'.⁴⁵

Physical and mental defects render certain workers peculiarly susceptible to accidents.⁴⁶ "Quinby in reporting the absentee experience of the Hood Rubber Company, found that the accident rate was nine times as great in women rated as third class by physical examination, compared with those in the first class. In men, the third class showed nearly double the accident rate as the second class. These findings were observed in spite

44. Hart E. Fisher, M.D., chief surgeon, Chicago Rapid Transit Company, *The Mental and Physical Causes of Accidents*, Bulletin American Association Industrial Physicians and Surgeons, May, 1928, pp. 5-8. Farmer, Eric: *Recent Research into the Causes of Accidents*, Journal Industrial Hygiene, March, 1932, p. 86; *The Organization and Conduct of a Plant Medical Department*, Pennsylvania Journal of Medicine, February, 1929, p. 352. Fisher, Boyd: *Mental Causes of Accidents*, passim.

45. Bulletin 276, United States Bureau of Labor Statistics, 1920, p. 32. Young, Arthur H.: *Some Economic Aspects of Safety*, Proceedings All Ohio Safety Congress, 1931, pp. 204-205.

46. Sappington, C. O.: *National Safety News*, April, 1928. See also "Age Factor in Industrial Accidents," *Monthly Labor Review*, October, 1932, pp. 844-845.

of the precautionary measure of special placement of third class persons in occupations involving low accident risk."

Accident prevention under workmen's compensation seems to be evolving toward a situation where, without any reduction of the legal, mechanical and supervisory efforts to secure safety through mass action it is clear that there is at least an equally large field of individual personal activity where more fruitful results may be expected. The latter field calls for close, continuous sympathetic knowledge of the individual. It involves a thorough physical examination for diagnosis and treatment as well as for employment purposes. This examination, it would seem, might well be performed by the employee's family physician, who would naturally give the necessary treatment. This would incidentally be far more economical than the many repeated examinations given by the physician of each plant where employment is sought.

Such a plan involves several important changes in present practices. It demands that the general practitioner shall familiarize himself to some extent with the physical and mental demands, and working conditions in the occupational opportunities of his patients, something that modern medical practice is already beginning to recognize as necessary for proper diagnosis and treatment of industrial workers. It also would require the personnel departments of industry in cooperation with the plant medical adviser to prepare job analyses for hiring that would give far more attention than at present to the physical and mental qualifications. If such a plan were worked out under the supervision of the local medical society it might well be the beginning of the closer cooperation of industrial and general medicine that would, in turn, prove a starting point for the solution of many other problems besides that of accident prevention.

CHAPTER III

ADMINISTRATION—INSURANCE CARRIERS

The form of certain of the institutions through which insurance is administered has had important effects on medical relations. The most common type of administration, and the one toward which other forms seem to be tending, is the commission. This is composed of a varying number of members, usually appointed by the governor, and frequently with little security of tenure of office. In some states these members are purely political employees, subject to all the defects of the spoils system.⁴⁷ Their duties differ from state to state but commonly include passing on all claims for compensation, fixing medical fees and supervising insurance relations. Although almost every step in the handling of compensation centers around medical problems and depends on medical judgments, only a single state—Washington—makes any legal provision for a physician on any governing administrative body.

Compensation legislation always implies some form of insurance and in many states such insurance is mandatory. Since compensation makes all accidents "arising out of and in the course of employment" compensable according to a definite scale, thus removing all the risks and uncertainties of litigation, the insurance problem is greatly simplified in comparison with the situation under the liability system.

The form, functions and activities of the insurance carrier have a dominating influence on the operations of the compensation system and have been especially significant in medical relations, since the carriers usually assume or are granted most of the rights and duties which the law vests with the employer. When the law requires medical care of the employee by the employer,

47. In Alabama, Alaska, Kansas, Louisiana, New Hampshire, New Mexico, Rhode Island, Tennessee and Wyoming, all or certain phases of administration are assigned to courts. The duties of commissions have been summarized by Carl Hookstadt in *Comparison of Workmen's Compensation Insurance and Administration*, Bulletin 301, U. S. Bureau of Labor Statistics, 1922, pp. 23-24; analysis of forms of organization may be found in Bulletin 496, November, 1929.

the responsibility for that care, with all the accompanying powers and duties, are assumed by the carriers.

The carrier of insurance takes one of four forms: (1) stock company; (2) mutual company, under which may be included "reciprocal" or inter-insurance exchanges; (3) a state fund, which may be "exclusive," permitting no other form of insurance except, in most cases, self insurance, or "competitive," sharing the field with other forms, or (4) a "self insurer," which the employer may become if he can show adequate financial responsibility.

The forms of insurance existing in the different states are shown in the accompanying table.⁴⁸

The stock companies were already in control of the liability business and many of their clients under that system were retained under compensation. They claimed to monopolize the actuarial knowledge required for compensation insurance, although it was quickly discovered that liability experience was a poor guide for compensation work and most of the tables actually used were taken from European sources open to everyone. Even these were soon found inapplicable to many phases of American industrial and social conditions and were gradually discarded in favor of accident tables built on the basis of experience in various American localities and industries.

The commercial insurance companies had perhaps the largest and most efficient sales organization to be found in modern society, which was as capable of campaigning for propaganda as selling insurance for profit. The personal and financial relations of such an organization can compel the placing of much insurance almost regardless of cost. They had and still retain the powerful backing of most banks and holding companies, and of all insurance brokers, on whom the decision as to the placing of most of the largest insurance accounts rests.⁴⁹

They have vigorously, and their opponents say wiciously, fought all efforts to establish either exclusive or competitive state funds, publishing periodicals and

48. Adapted from Bulletin 541, U. S. Bureau of Labor Statistics, September, 1931, p. 897.

49. Archer, W. C.: What Competitive Insurance Is, Bulletin 385, U. S. Department Labor Statistics, May, 1925; also, Bulletin 511, 1930, p. 245, for restrictions imposed by holding companies, and for personal and financial influences.

Compensation and Insurance Systems

State	Insurance Required in	
	State Fund: Exclusive or Competitive	Private Com- panies or Self Insurance
Alabama		Either
Alaska		"
Arizona	Competitive	"
California	"	"
Colorado	"	"
Connecticut		"
Delaware		"
District of Columbia		"
Georgia		"
Hawaii		"
Idaho	Competitive	"
Illinois		"
Indiana		"
Iowa		"
Kansas		"
Kentucky		"
Louisiana		"
Maine		"
Maryland	Competitive	"
Massachusetts		Private companies
Michigan	Competitive	Either
Minnesota		"
Missouri		"
Montana	Competitive	"
Nebraska		"
Nevada	Exclusive	
New Hampshire		Self insurance
New Jersey		Either
New Mexico		"
New York	Competitive	"
North Carolina		"
North Dakota	Exclusive	
Ohio	"	Self insurance ¹
Oklahoma		Either
Oregon	Exclusive	
Pennsylvania	Competitive	"
Philippine Islands		"
Porto Rico	Competitive	"
Rhode Island		"
South Dakota		"
Tennessee	Competitive ²	"
Texas		Private companies
Utah	Competitive	Either
Vermont		"
Virginia		"
Washington	Exclusive	
West Virginia	"	Self insurance ³
Wisconsin		Either
Wyoming	Exclusive	"
United States longshoremen's act...		

1. Employers accepting the act must furnish proof of solvency or give bond; no other provision as to insurance.

2. Coal mining only.

3. Compulsory as to coal mining.

maintaining extensive publicity organizations to circulate propaganda derogatory to such funds.⁵⁰

The stock companies entered the field loaded with the opprobrium of their previous operations under liability. Although one of the incentives to the establishment of compensation was a desire to get rid of the influence of liability insurance companies, they dominated much of the legislation and administration of compensation.

The situation at the time of the adoption of compensation legislation and the tactics of the stock companies in New York State were duplicated almost everywhere:⁵¹

"The competitive activities of the New York State Fund have been attacked most violently by Mr. J. Scofield Rowe, vice president of the Aetna Life Insurance Company, in letters addressed to the governor of the state, and later reprinted, with additional matter, in pamphlet form. Mr. Rowe refers to the competition of the state fund as 'the confiscation of an established insurance clientage through legalized bribery.' The assumption on which Mr. Rowe proceeds is that the casualty companies have a vested right to conduct the business of workmen's compensation insurance upon which the state may not rightfully encroach. This cannot be conceded for a moment. The historical fact is that the advocates and promoters of workmen's compensation legislation intended that this insurance should be provided exclusively by state funds or state mutuals. In fact, this legislation was bitterly opposed by the casualty companies, and the latter by this course alone forfeited any claim to be intrusted with the administration of insurance under the compensation laws. The casualty companies secured admission into this field only in the face of vigorous protests on the part of labor and persons sincerely interested to secure the best possible administration of compensation insurance. The representation that the state funds are invading a field that legitimately and rightfully belongs to the casualty companies is sheer effrontery. It is rather the casualty companies that are attempting to seize a business which was designed to be conducted on a non-profit-taking basis. It cannot be held that the presumption is in favor of stock-company administration of this

50. The Workmen's Compensation Bulletin is an example of such a periodical. Baldwin, F. S.: State Insurance Fund, Bulletin 212, Bureau U. S. Labor Statistics, June, 1917, pp. 131-132. Duffy, T. J.: Ohio's Experience with State Insurance, Bulletin 210, U. S. Bureau of Labor Statistics, May, 1917, pp. 227-233. For full discussion of forms of carriers, see Bulletin 212, U. S. Bureau of Labor Statistics, June, 1917, pp. 66-173, and Bulletin 511, 1930, pp. 197-278. See especially Final Report of the Joint Legislative Committee on Housing (New York), Legislative Document 48, 1913, pp. 77-87.

51. Baldwin, F. S.: State Insurance Fund, Bulletin 212, U. S. Bureau of Labor Statistics, June, 1917, pp. 131-132; Bulletin 511, 1930, pp. 228-229.

new form of insurance simply because the companies possessed a monopoly of insurance under the old liability régime. Compensation insurance is essentially different from liability insurance. As has been previously pointed out in this paper, it is compulsory and collectivistic in character; a compensation premium is in reality a tax, the proceeds of which are disbursed under the supervision of a state commission for the benefit of injured workers and their dependents. The state fund stands for a system of direct collection and payment of this tax, as opposed to the wasteful method of farming out, represented by stock-company administration of insurance in this field. The alleged vested interest of the old-line companies in this business cannot be recognized as paramount to the plain interests of employers and employees at large which should always control legislation with respect to compensation insurance."

The defenders of state funds maintained that a legal compulsory assessment on employers to provide compensation to injured workers was in the nature of a tax and that to permit the diversion of any portion of that tax to the pockets of insurance companies was as unjust as would be a similar diversion of taxes for education or public protection. "We are inclined to forget," said Carl Hookstadt,⁵² "that a compensation law is a *workmen's* compensation law. It is not an employers' compensation law, nor a physicians' compensation law, nor an insurance companies' compensation law, nor a compensation law for the benefit of those who administer the law. It is for the employee, and the interest of every one else should be subordinated."

When the actual distribution of the sums collected is examined, there is much evidence to indicate that compensation laws, as administered today, are almost as much directed to the support of insurance companies as to the relief of injured workers. The authority just quoted gives a comparison of the cost of insuring in the various forms of carriers:⁵³

"The average expense ratio of stock companies is approximately 38 per cent; of mutual companies, about 20 per cent; of competitive state funds, about 10.6 per cent; and of exclusive state funds, about 4 per cent. Under an exclusive state fund, therefore, the cost to employers would be 30 per cent less than under stock insurance and 16 per cent less than under mutual insurance. The total saving to insured employers of the United

52. Bulletin 281, U. S. Bureau of Labor Statistics, June, 1921, p. 188.

53. Bulletin 301, U. S. Bureau of Labor Statistics, April, 1922, p. 21.

States, if all were insured in exclusive state funds, would be over \$30,000,000 annually."

The ten years since the foregoing statement was made has not altered the situation in favor of the stock companies. On the contrary, it has stabilized the additional costs at a somewhat higher level while recently published reports seem to indicate that experience has enabled the state funds to reduce further their cost of operation. Most states give the compensation commission power to adjust rates, and an agreement which is now standard throughout most of the United States permits 41.5 per cent of the premiums collected by the companies to go for expense. This is divided as follows: acquisition costs, 17.5 per cent; claim adjustments, 8 per cent; auditing of pay-rolls, 2 per cent; inspection, presumably for safety work, 2.5 per cent; taxes (one half of federal tax), 4 per cent; and general or administrative expenses, 7.5 per cent.⁵⁴

As a matter of fact, in many states the stock companies succeed in retaining more than this 41 per cent,⁵⁵ which means that about 42 per cent of all the funds raised for compensation purposes, when the insurance is carried by stock companies, goes to pay the expenses and profits of such companies. To be sure, all the spokesmen for the companies deny that any profits are obtained from compensation business.⁵⁶

54. Hulvey, Charles H., and Wandel, William H.: *Workmen's Compensation and Auto Liability Insurance in Virginia, 1931*, p. 38.

55. Hulvey and Wandel: *Workmen's Compensation and Auto Liability Insurance in Virginia*, pp. 56-67. Report of the Insurance Commissioner on the Investigation of the Workmen's Compensation Act of Maine, 1930, pp. 19-22. A statement of George S. Van Schaick, New York state superintendent of insurance, reported in the U. S. Daily, Sept. 30, 1932, says: "While the new schedule of rates was calculated on the basis of a customary 40 per cent loading for expenses of investigation and adjustment of claims, acquisition and field supervision, general administration, inspection, rating and taxes, it was found that those companies operating on a non-participating basis and writing the preponderance of business actually incurred during the year 1931 an expense ratio of 45½ per cent."

56. F. Highland Burns, before the American College of Physicians and Surgeons (Report, Symposium and Surveys, p. 38), says: "In making the rates, we are allowed factors for the compensation payments, medical expenses, and the expense of putting business on the books and administering it. Not one cent is allowed for profit. The only profit we are supposed to get is the interest earnings on the reserve we have to carry for unexpired business and unpaid losses. I assure you that in the past ten years the companies' losses in the field of workmen's compensation have been very great. It may very readily be asked, if this is so, why do the companies continue to write it? For several reasons, one being the hope that the situation will improve, which it has done in the past two years, and another the realization that if it is given up the tremendous organizations the companies have to handle this business, built up at great expense of effort and money, would have to be scrapped, so with the optimism of youth we are looking to the next year to bring us some reward for our efforts."

This claim becomes a heavy indictment of the efficiency of such companies when it is noted that the combined percentage allowed for claim adjustments, auditing, inspection and general administration is 20 per cent, and that all of these functions are performed by many state funds under the supposedly inefficient management of governmental bodies for about one-half that percentage. There is no dispute of these figures. They are defended as the necessary cost of competition in compensation insurance. The charge of 17.5 per cent for "acquisition cost" is to meet the expense of soliciting accounts and is not permitted to mutuals or state funds. But compensation insurance is compulsory and no amount of sales effort can change the amount written—it can only decide who will write it.⁵⁷

The state funds suffer under many handicaps from which the insurance companies are free. In most states they are forbidden to spend any money for acquisition, and in the others they can do little more than circularize employers on the advantages the state fund can offer. The Arizona Fund reports:⁵⁸

" . . . It must be kept in mind that our entire business, with the exception of the non-competitive civic classifications, has been gained without affirmative effort on our part or personal solicitation of any kind. There are several hundred solicitors for the private insurance companies in Arizona who receive substantial commissions on policies obtained and are therefore keenly interested in the development of their business. Nevertheless the Fund is the largest underwriter of compensation in Arizona, and the total of our underwritings, exclusive of the self-rating and civic classifications, amounts to more than 40 per cent of the total of all competing companies for the current year."

State funds are further handicapped in most competitive states by a requirement that they quote the same rates as the private companies for the original underwriting, and then return the amounts saved as "dividends" at the end of the year. The insurance companies have fought bitterly any legislation to permit competitive state funds to quote original rates that would show clearly their economy of operation and

57. Report on Workmen's Compensation by Massachusetts Commission to Investigate Practices and Rates in Insurance, 1915, p. 31. Downey, E. H.: Work Accident Indemnity in Iowa, 1912, pp. 64-67.

58. Report Industrial Commission of Arizona, 1927, p. 5.

abolish this cumbersome and wasteful system of collecting, retaining for a year and then repaying such large sums.⁵⁹

There are constant charges and countercharges among the insurance companies themselves that rates are being secretly cut, that secret rebates are granted on compensation insurance, to secure other profitable lines controlled by the same employer and that state laws and regulations are constantly violated.⁶⁰

The additional expense is defended on the ground that the stock companies give greater service to the employers. Leaving aside the question of whether compensation contributions are collected to supply service to employers, it must be recognized that the insurance companies were the pioneers in urging safety measures and in assisting employers to introduce safety practices. The companies cannot be blamed because these measures did not produce the expected results. The methods urged were the ones most generally approved at the time.⁶¹

In the beginning, the state funds showed many of the weaknesses that might be expected of a political experiment in so new and extensive a field. They made costly mistakes in financing although, to quote Carl Hookstadt⁶² again, "Thus far no injured workman has lost his compensation because of the insolvency of state insurance funds, nor has any large mutual company become insolvent. On the other hand, there have been several disastrous failures of private stock companies during the last three or four years. These failures have resulted in hundreds of thousands of dollars in unpaid claims."

Perhaps the sharpest and at the same time the fairest criticism of the defects of the state funds in the first decade of their operation is made by E. H. Downey, who is by no means antagonistic to such funds. He⁶³ says:

"The extreme showing of economy made by many American state funds has been secured at some sacrifice of efficiency. Salaries are too low to retain competent employees, the staffs

59. Report Industrial Commission of California, 1916-1917, p. 23.

60. Hobbs, C. W.: Workmen's Compensation Situation, Weekly Underwriter, Sept. 21, 1929, pp. 631-634. Final Report Joint Legislative Committee on Housing, New York Legislative Document 48, 1923, p. 78.

61. Hookstadt, Carl: Comparison of Workmen's Compensation Insurance and Administration, Bull. 301, U. S. Bureau of Labor Statistics, 1922, p. 18.

62. Bulletin 301, April, 1922, p. 21.

63. Workmen's Compensation, 1924, pp. 99-105, *passim*.

are too small for the work to be done, claim payments are needlessly delayed, accident prevention is neglected and statistical information of great social value is withheld. But a really efficient administration of a large insurance monopoly would certainly not cost more than 10 or 15 per cent of benefits under an adequate scale. . . .

"Public officials charged with the administration of a workman's insurance fund might be expected to apply the law in a liberal spirit and to make prompt payment a point of conscience. In actual performance, however, there is little to choose in these respects between state and private insurance. Illiberal settlements, narrow definitions of industrial injury and the denial of compensation on technical grounds appear to be as prevalent in Washington and West Virginia as in New Jersey and Alabama. The adjustment of claims is as disgracefully tardy in Ohio as in Pennsylvania. The actual administrations of state funds are too apt to regard themselves as trustees for the insurants rather than the beneficiaries and to look to low premium rates rather than liberal settlements as the goal of endeavor. Claim adjusters, by whomever employed, and whatever their antecedents, take to claim shaving as sparks fly upward. . . .

"In risk classification, in rate making, and in accident prevention the monopolistic state funds have made little use of their rich opportunities. The rate manuals of Ohio, Washington and West Virginia—to cite only conspicuous examples—are full of arbitrary groupings, minute subdivisions of a single industry and unwarranted discriminations between establishments of identical hazard."

So far as financial administration is concerned, nearly all of the state funds seem to have reached an extremely satisfactory stage. Even their most hostile rivals have ceased to circulate rumors of their approaching bankruptcy, and their cost of administration has probably reached as low a point as and in some cases even a lower point than is consistent with efficiency. The charge on the premiums for the cost of administration varies from nothing in Nevada, where the interest on the investment of the surplus meets all charges,⁶⁴ to from 10 to 15 per cent in a few of the funds.

In the beginning, some of the Ohio employers were hostile to the exclusive state fund,⁶⁵ but in February

64. The Monthly Labor Review, June, 1929, p. 143, quotes the report of the Nevada Industrial Commission as reporting that "every dollar of premiums collected from employers is available for the payment of injured employees, as the earning from our invested reserves exceed our administrative expense by approximately \$25,000 per year."

65. See "Study of Workmen's Compensation Insurance Laws and Services—Monopoly or Competition," Report of Committee of Cincinnati Chamber of Commerce, 1923.

1932 the Ohio Manufacturers Association adopted a platform, one plank of which said "We believe that by the present arrangement a larger portion of the Ohio manufacturer's dollar goes directly to relief than anywhere else in the United States."

This financial advantage is at last resulting in a steady growth of competitive state funds in spite of the sales methods and hostile propaganda of the stock companies. Yet that hostility has been sufficiently effective to prevent the establishment in recent years of state funds in states in which they were not originally created.⁶⁶

On the other hand, every province in Canada, with the single exception of the Yukon Territory, has adopted the exclusive fund plan.⁶⁷

State funds have been hampered in administration by the fact that they are compelled to accept all risks, while stock companies may select the most desirable, by their inability to employ salesmen, by the prejudice against state operation which is constantly fanned by propaganda addressed to employers, by their inability to handle other lines of insurance for the employers and, finally, at least in their early years, by their lack of a trained staff.⁶⁸

While it is impossible to generalize, without warning that there are exceptions, most of the state funds are now giving more attention to accident prevention.⁶⁹ There would also seem to be a growing realization on the part of some state funds of the importance of medical care and the necessity of establishing better relations with the medical profession.⁷⁰

The mutual insurance companies are associations of employers, formed on a "no profit" basis to enable a number of firms, often in the same line of business, to share their risks. Mutual associations, like the state funds, represent an effort to escape the excessive

66. Workmen's Compensation Bulletin, October, 1927, p. 3.

67. Cochrane, Cornelius: Quebec Adopts Exclusive State Fund, American Legislation Review, June, 1931, pp. 247-248. Kearns, Thomas F.: Safety Education in Industry Under State Supervision as a Means of Preventing Accidents, Bulletin 485, U. S. Bureau of Labor Statistics, pp. 175-180.

68. Stewart, Ethelbert: Bulletin 536, U. S. Bureau of Labor Statistics, April, 1931, p. 113.

69. Report Industrial Commission of Arizona, 1929, p. 3. Report of Department of Industrial Relations of California, 1927-1930, pp. 42-43. Report Industrial Commission of New York, 1930, p. 9.

70. Arizona and California Reports.

charges of the stock companies, and their rates are usually from 10 to 15 per cent lower than those charged by such companies.⁷¹

The following description of events in Wisconsin could be paralleled in many other states:⁷²

"When our Wisconsin compensation law went into effect in September, 1911, we found these companies in combination, issuing a rate book identical in language except the title-page. The rates were preceded by an analysis of the law false in nearly every conclusion; so much so, that the insurance commissioner ordered it withdrawn. These rates were twice as high for compensation as for liability. The rates remained unchanged until February of this year. It was certain that these companies would write no compensation insurance under such rates and they did not. Had we been dependent upon them for insurance, no employer requiring insurance would have elected to go under the act. But the act provided for the organization of mutual companies and one such organized and began business concurrently with the act. This company wrote compensation only. It did a large and completely successful business. It charged but 40 per cent of the old line rates, which rate proved ample. In the meantime the casualty companies prophesied the failure of the act. They fought it boldly and openly at first, and covertly and unfairly later on."

"Self insurers" are always large firms whose financial resources enable them to give security for their ability to meet expected losses. They generally have plant medical services and claim to be more generous than the law requires in granting both cash and medical benefits. The medical side of their work has given rise to important developments that will be treated later. Self insurers have been frequently criticized for using the threat of discharge to prevent their employees from taking advantage of compensation rights, and also for the prejudicial character of the evidence given by their medical staff in compensation cases.⁷³

The financial difference in the operation of the different forms of insurance carriers deserves the emphasis that has been placed on it because it is difficult to

71. Report of the Insurance Commissioner on the Investigation of the Workmen's Compensation Act of Maine, 1930, pp. 15-17.

72. Crownhart, Charles W.: *American Legislation Review*, June, 1913, p. 268. See also, Blanchard, Ralph H.: *Liability and Compensation Insurance*, 1917, p. 185. *First Quadrennial Report Workmen's Compensation Commission*, Alabama, pp. 76-80.

73. Report Industrial Commission of Minnesota, 1929-1930, p. 25. McShane, O. F.: *Under What Conditions Should the Self-Insuring Privilege Be Granted, If at All?* Bulletin 432, U. S. Bureau of Labor Statistics, pp. 172-181.

find any other phase of their relations to compensation where the difference is of great importance. The domination of the stock companies over the entire situation was so great that they established a pattern of administration for all other forms of insurance. Although at the time of their establishment much was said about the decreased cost of administration of state funds making possible more liberal compensation, better medical care and greater safety efforts, it is hard to find any general signs of superiority on the part of such funds in these respects. States with exclusive or competitive state funds have no higher compensation schedules on the average than those having only stock company carriers. The state funds, in their defense propaganda, stress their savings in premiums, seeming to hold that compensation is for the benefit of employers, while stock companies take the same attitude—after seeing that premiums are sufficiently high to compensate the companies.

The efforts of some claim adjusters to prevent legal compensation reaching the injured workers sometimes exceeds even the limits of criminal law. In New York State, insurance companies continuously underpaid claimants until the total of such reductions reached \$5,700,000. The adjusters of the New York State Fund followed this example to the extent of about \$50,000, for which several of them were indicted, which ended the practice.⁷⁴

In Montana there is an opportunity to compare the operations of self insurance, stock companies and a state fund as to amount of compensation paid. According to the Report of the State Industrial Accident Board,⁷⁵ during the fifteen years from 1915 to 1930 the self insurers paid an average of \$60.18 per compensation case, the private companies \$27.51, and the state fund \$72.41.

Nor can it be claimed that medical relations are either better or worse under state funds. In Ohio the state medical society has expressed itself as well satisfied with the medical relations with an exclusive state fund, but there are other states with such funds where the

74. Dawson, Miles M.: *State Accident Insurance in America a Demonstrated Success*, American Labor Legislation Review, March, 1920, p. 12. For similar tactics by stock companies in Illinois, see Hookstadt, Carl: *Comparison of Workmen's Compensation Insurance, and Administration*, U. S. Bureau of Labor Statistics, Bulletin 301, pp. 16-17.

75. Report Industrial Accident Board, of Montana, 1930, pp. 23-24.

worst features of contract practice predominates, while some state medical societies have made satisfactory relations with systems having only stock or mutual companies.

The California physicians fought the proposal to make the state fund exclusive on the ground that, of the \$11,000,000 of premiums which the competitive state fund had been able to refund to employers because of greater economy of administration:⁷⁶

"A substantial amount of this profit has been made by paying a ridiculous minimum for physicians' services and by grinding down payments for hospital service far below the cost of rendering it, so that some of the hospital's service must be made up by private or organized philanthropy."

Missouri physicians also opposed a referendum to create an exclusive state fund.

The fact is that methods of administration, like the original legislation, depend far more on the continuous intelligent application of pressure by the interests involved than on differences in laws and administrative forms. Employers and insurance companies have been continuously alive to their interests and skilful in pressing them. The physicians have shown less capacity to protect their interests and have suffered the consequences of that incapacity.

76. Editorial, *California and Western Medicine*, February, 1927, p. 217. The Report of the Committee on Industrial Medicine, to the Council California Medical Association, typewritten, pp. 3-4, elaborate these charges.

CHAPTER IV

GROWTH IN PROVISIONS FOR MEDICAL CARE

Compensation systems, like other social institutions, were born out of previously existing institutions and are constantly adjusting themselves to meet the strains and stresses of the social environment in which they function. The present situation is the result of such adjustments during the last twenty years. Changes proceed from various sources. Few state legislatures adjourn without considering a number of amendments to compensation legislation. The commissions that interpret this legislation make new regulations constantly. Both the laws and the regulations are the basis of appeals to various courts, whose decisions bring other changes.

Analysis of these changes shows that there are certain very clear and general lines of evolution, the principal ones of which are as follows:⁷⁷

1. A steady increase in the amount of cash compensation granted. This includes increases in the percentage of wages used as the base for calculating compensation, in the maximum wages which the law fixes as such a base, and in the schedule of compensation.

2. A decrease in the length of the "waiting period" after an accident, during which no compensation is paid but during which medical aid is almost always granted.

3. An increase in the scope of coverage either in the number and character of the industries included or in the nature of injuries compensated—such, for example, as occupational diseases.

4. A continuous increase in the amount of time and money authorized for medical care, which in a majority of the jurisdictions is now practically unlimited.⁷⁸

77. For tabulation of these changes see Insurance Bulletin 37, Chamber of Commerce of the United States. For conflicting character of legislation see Dwan, Ralph H.: *Workmen's Compensation and the Conflict of Laws*, Monthly Labor Review, March, 1928, pp. 56-73. See also Handbook of Labor Statistics, 1931, Bulletin 541, U. S. Bureau of Labor Statistics, p. 907.

78. Medical changes are tabulated in appendix A.

Due to the lack of influence, in the formative stage, of the workers for whom the law was designed, and of the physicians on whom so much of its operation depends, compensation and medical benefits were both ridiculously inadequate. A study of the table showing medical benefits reveals the fact that in the early stage of compensation, 22 states limited medical care to a period of 30 days or less and that 24 permitted no more than \$100 to be expended for this service. Five of these either gave no medical care whatever or only a funeral allowance to living dependents.⁷⁹

Downey⁸⁰ has pointed out the close and causal connection between low compensation and limited medical benefits:

"The niggardly limits upon medical aid so prevalent in American compensation acts are, in fact, corollary to inadequate pecuniary benefits. When the price of a hand is set at \$2,000 there is no great incentive to employ the best that modern surgery has to offer. But if compensation for the loss of a hand were a life pension at one-half of wages, neither employers nor insurance carriers would stint their efforts to save the industrial use of a threatened member. Given an appropriate scale of indemnity for death and permanent disability and no objection will anywhere be raised to unlimited medical benefits. . . .

"For inadequate death and disability benefits there is at least the excuse of low cost to employers, but for the insufficient medical, surgical and hospital care even this pretext fails. The cost of unlimited therapeutic relief is, in per cent of payroll, a bagatelle. Yet it is in their medical provisions that the American compensation laws are most absurdly deficient. . . . The effect of the niggardly medical limitations in our compensation acts is to deprive thousands of injured workmen of that therapeutic care which would prevent permanent disability and to throw tens of thousands into charity wards and free clinics."

Belated recognition of the fact that the greatest boon that can be conferred on the worker is not to hand him a meager cash stipend while he is disabled, but to restore him as quickly and fully as possible to a condition of health and productive employment, has led to rapid extension of the limits of medical care. At the

79. See also Williams, F. M.: *Medical Services and Hospital Fees Under Workmen's Compensation*, Bulletin 212, U. S. Bureau of Labor Statistics, June, 1917, p. 294. Meecker, Royal, pp. 94-95; *Handbook of Labor Statistics*, Bulletin 541, September, 1931, pp. 906-907.

80. Downey, E. H.: *Work Accident Indemnity in Iowa, 1912*, pp. 59 and 132.

present time (1932) fifteen of the jurisdictions (state, federal and possessions) give unlimited medical service, and in several others the limits have been so extended or made flexible through commission action as to be practically unlimited.

Within recent years this tendency to expend money on physical restoration has possibly proceeded at an even more rapid rate than the liberalization of benefit for financial care. Ethelbert Stewart, Commissioner of the United States Bureau of Labor Statistics, stated in April, 1931, that, "through the workmen's compensation commissions of the United States, we pay the physicians and hospitals \$72,000,000 a year." He⁸¹ comments further on the relative increase of medical and compensation payments:

"When we began the administration of workmen's compensation laws, the relation of doctors' bills to compensation, or to the amount that the injured workman got, was 5 per cent. Today it is 35 per cent and in temporary cases it ranges from 50 to 75 per cent of the amount that the injured workman gets."

The interests of employers and insurance companies have led them to take an antagonistic attitude toward this increase of medical care. Almost automatically they react against any increase in payments. "The only real opposition to the liberalization of the compensation laws has come from the private insurance companies. Naturally a liberalization of the law cuts into their profits."⁸²

This attitude is stated clearly by one of their own spokesmen⁸³ in commenting on recent developments in New York State:

"The employer . . . has been amazed and more than a little bit startled—by the tremendous increase in the medical and hospital costs under the Workmen's Compensation Law, and is wondering just where they are to stop—if they are to stop. He is alarmed when he discovers that the medical losses incurred in 1928 (the last year for which complete figures are

81. Stewart, Ethelbert: Bulletin 526, United States Bureau of Labor Statistics, April, 1931, pp. 33 and 74. See pp. 97 for actual figures.

82. Campaign for a New Compensation Law in Rhode Island, American Legislation Review, December, 1925, p. 297. Proceedings, House of Delegates, Tennessee State Medical Society, Journal Tennessee State Medical Association, April, 1929, p. 490; Journal Iowa State Medical Society, July, 1929, p. 341.

83. Daly, Mark A. (general secretary, Associated Industries of New York): Bulletin of the Association of Casualty and Surety Executives, November, 1931, p. 7.

available) have increased more than 500 per cent over the same losses in 1919, when the law was amended to remove the sixty day limit. In 1919 there were 2,219,100 employees covered by the law and the incurred medical costs were \$3,414,225; in 1928 there were 2,930,353 employees covered and the medical costs were \$9,731,081. You'll note that the number of employees increased only 32 per cent while the medical costs increased 185 per cent. The employer cannot find any satisfactory explanation for such a difference. . . . So he asks me . . . why it is so, and I have no answer except the obvious one—that the doctors and the hospitals are charging more for their services now, proportionally, than they did in 1919, that the administration of the law has been disproportionately 'liberalized'."

Within recent years even employers and insurance companies have begun to look on the medical relief in quite a different manner from what they did at the beginning. The steady increase in compensation benefits, making medical neglect far more expensive, may have been one of the influences responsible for this change in outlook. At any rate there is now a decided inclination to favor thorough and competent medical care, although the effort to beat down the compensation to physicians, surgeons and hospitals, and the devices created for this purpose frequently defeat the objective.

Gradually a far more fundamental conception of the place of medical care in compensation has begun to gain public recognition and to find expression in legislation and administrative activities. When all the functions at the various stages of compensation are examined, it becomes evident that such care is by all odds the most important feature of the whole compensation situation, thus furnishing another illustration of the stone that was rejected becoming the cornerstone of the whole vast structure.

We have already seen that the failure of the accident prevention program to reach its high expectations was due in no small part to focusing attention on mechanical, financial and disciplinary measures to the neglect of medical control of individual physical and mental adjustments to the productive process.

When the accident takes place, the first person in the compensation system to come in contact with the victim is the physician. The character of the treatment he gives and the response of the patient to that treatment, often largely determined by his confidence

in the skill of the practitioner, are the decisive factors in all succeeding steps in compensation. If the injury is slight and properly treated, this is the first and the last step. The injured worker is returned to work during the "waiting period" and the only assistance received is the medical attendance.

Owing to the tendency to overlook all features not affecting the financial and insurance side of compensation, little notice has been taken of the fact that the overwhelming majority of accidents come within this waiting period⁸⁴ and consequently receive only medical relief. The investigations of the National Industrial Conference Board⁸⁵ showed that, in 1920, only 2.86 per cent of the injuries received were of such severity as to require the payment of compensation benefits, while a later investigation reduced this figure to 2.54 per cent. By 1930 it had been reduced to 1.55 per cent.

These figures are based on reports from the firms associated with the National Industrial Conference Board, which employ between 600,000 and 1,000,000 employees, varying each year. These reports are usually accepted as more complete and accurate than the more extensive tables whose reliability has already been discussed. If these figures are taken as a fair sample of the general accident situation, one cannot avoid the startling conclusion that excessive stress on the cash payments for disability of compensation has led to basing the entire structure of administration on only 1.55 per cent of the accident base. Such a building plan naturally has given the completed structure a badly unbalanced appearance.

It must be remembered that of these 98.45 per cent who do not come within the scope of the financial provisions of the compensation law, a large number received medical care within the provisions of that law. Yet even for this care the conditions of practice are determined largely with regard to protection of the financial interests of those who pay out cash compensation to the 1.55 per cent. Certainly the vast majority of these accidents are very slight, usually calling for little more than "first aid," but every industrial practi-

84. Only one state, Oregon, has no waiting period; in five states it is three days; in one, five; in thirty-two, one week; in two, ten days; in two, two weeks, and in one, thirty days.

85. Medical Care of Industrial Workers, 1926, p. 40, and edition of 1931, p. 81.

tioner has learned that neglect of such minor injuries is a prolific cause of serious after-effects.

Consider next the treatment of the fraction entitled to compensation. Compensation rates are classified according to the degree of injury, as follows: death, permanent total disability, permanent partial, temporary total, temporary partial and medical but noncompensable. The noncompensable has just been considered, but it should be added that if only those accidents which involve "time lost" and a compensation claim are reported, which is the practice of most commissions, this noncompensable classification contains about half the cases. In Virginia, for example, 47 per cent of the "temporary total" injuries recovered within the seven day waiting period and did not, therefore, come within the scope of the financial features of compensation.⁸⁶ What effect this waiting period may have on the cash payments was seen when New York reduced the period from fourteen to seven days and the payments increased one million dollars the next year.

All these basic classifications are based on medical judgments, as are also the multitude of individual subclassifications within these basic ones, which form the elaborate schedules of compensation. Unfortunately, owing to the complete lack of medical cooperation in the formative stages of compensation legislation, these schedules were usually drawn up by laymen without professional advice. The result would be ludicrous if it were not the basis on which dismembered human beings are compensated. Fingers, hands, feet and limbs are located and described in ways that no anatomist would recognize and so that their loss is a wholly different injury in one state from what it is in another:⁸⁷

"The anatomic boundaries of different parts of the extremities vary in the laws of different states. In some states the hand ends at the wrist, in others it includes all tissue to the elbow. In like manner the foot varies from ankle to knee. Limitations of the arm are naturally dependent upon those for the hand, in some states the arm extending to the elbow, in others including all tissue to the wrist. The leg may include tissue only to the knee, or it may extend to the ankle. In several of the states

86. Hulvey and Wandel: *Workmen's Compensation and Automobile Liability in Virginia, 1931*, p. 8.

87. National Industrial Conference Board: *Workmen's Compensation Acts in the United States—the Medical Aspect, 1923*, p. 101. On page 102 is a complete table showing by states such anatomic variations in legal provisions for dismemberment under workmen's compensation laws. See also Kensler, Henry H.: *Accidental Injuries, 1931*, pp. 38-43.

compensation varies for loss of different parts of a member. In two states, laws contain the provision that amputation between two joints shall be estimated as amputation at the joint nearest to the point of amputation. Amputations between the knee and hip are excluded from this provision. In only one state, West Virginia, is the complete anatomic classification of hand, forearm, arm, foot, leg and thigh recognized in the law."

On this foundation of an anatomy, which he certainly never learned in any medical school, the physician is compelled to make his judgments as to the injury suffered. His work is rendered more difficult by legal definitions of accident and disease that are also at variance with scientific accuracy. The original definition of an accident by the English courts has been modified by later decisions until it has been held to consist of three components: "a sudden occurrence, producing a quick result, and coming from without." Of the difficulties of applying this definition in medical practice, Dr. Henry H. Kessler⁸⁸ says:

"To the surgeon the definition of sequence of (1) sudden occurrence, (2) prompt result, and (3) occurring from without, is incompatible with his knowledge of pathology and makes it difficult for him to render an opinion. The framers of the above legal definition apparently had in mind trauma of a mechanical nature only, not realizing that there are other agents, such as chemical, bacterial and thermal, whose action and effects would not come within the meaning of the definition. The time and manner of action of bacterial agents, for example, depend upon the virulence of the organism and upon the resistance of the host. There may be, however, a combination of mechanical trauma and bacterial invasion, as in traumatic pneumonia following fractured ribs. Here there would be no argument about the definition, as mechanical trauma with its sequelae would be present, namely, the laceration of the lung by the rib fragment producing an avenue for the invasion by bacteria and at the same time causing a lowering of the patient's resistance.

"The word 'sudden' in the definition is also open to criticism unless it is understood to include the cumulative effect of sudden happenings, individual effects of which are of no consequence, such as beat elbow and neuritis which results from the constant vibration of a power press.

"The third part of the definition, 'occurring from without,' presumes an external cause as the origin of the injury. This is, however, incompatible even with forms of mechanical trauma, as force may not only be direct (from outside) but also

⁸⁸ Kessler, Henry H.: *Accidental Injuries*, 1931, pp. 25-26.

indirect from within, as in muscular strains from lifting. Consequently, whether or not an injury or accident is to be construed as compensable within the meaning of the act will depend in a great measure on the elastic interpretation placed on the definition of 'an accident'."

This continuous conflict between lay legal and financial definitions of pathologic conditions and the conclusions of science appears again and again. Practically all compensation jurisdictions recognize and compensate and, therefore, require the physician or surgeon to diagnose, certify to the existence of, and determine the extent of the disability caused by traumatic hernia, arthritis and neurosis, although the consensus of medical opinion is that there is considerable doubt as to whether there is any genuine pathologic condition that can properly be described by these terms.⁸⁹

These legislative enactments and administrative interpretations contrary to anatomic and physiologic facts were then given further validity by court action. The Wisconsin Supreme Court, in the case of *James McCarthy v. Industrial Commission*, decided Nov. 8, 1927, made the members of the Wisconsin Industrial Commission medical experts by court decision. The Court said: ⁹⁰

"In this case the trial judge apparently accorded the testimony of these physicians full faith and value. But it does not follow that the Industrial Commission attached any such weight to their testimony nor do we think they were bound to do so. If the testimony of these witnesses was contrary to their own expert knowledge upon the subject, they were at liberty to disregard it."

The California Industrial Accident Commission did not wait for the action of the courts to make its members superior judges of medical facts to those who had spent several years in a medical college. The commission announced in its annual report of 1927: ⁹¹

"For many years it has been the unchanging opinion of the medical profession that hernias are not of traumatic origin in the sense that they are rarely the result of a single strain or

89. Kessler: *Accidental Injuries*, pp. 125, 400. *Bulletin 564*, U. S. Department of Labor Statistics, April, 1932, pp. 137-158. Slater, B. J.: *New York State Journal of Medicine*, February, 1930, p. 205. *Klika v. Independent School District No. 79 (Minnesota)* N. W. R. 30 presents a legal decision definitely brushing aside medical scientific conclusions in regard to hernia to establish a legal definition for compensation purposes.

90. Wisconsin Labor Statistics, May 30, 1929, p. 3.

91. California and Western Medicine, April, 1927, p. 496.

injury but, rather, are caused by the successive strains to which the physical body is subjected in the ordinary course of living. Within the last two years the Commission, with its experience acquired in this field, reached the conclusion that the medical profession was not entirely correct in its position on this question."

Here we have the creation of symptoms of disease by court decisions and administrative action which at the same time confers superior medical knowledge on lay commissioners without subjecting them to the necessity of earning a diploma or passing an examination.

Notwithstanding these unscientific classifications and decisions, the physician practicing under compensation is required to assume the task of making judgments as to injuries on human beings who are really constructed according to the anatomy and obey the laws of physiology which have been so lightly set aside by legislators, courts and administrators. The physician is the one who makes the judgments and fits the individual case to these unscientific schedules and regulations. Once that is done, little remains except the clerical and administrative work of selecting the amount of compensation awarded by the schedule, adjusting disputes and paying the award to the injured employee.

The recent and rapidly growing movement to include occupational disease within the scope of compensation is adding to the functions of the physician.⁹²

"The responsibility for the arbitration of awards of compensation for occupational disease rests for the most part upon the medical adviser. The referee and commissioner look to him for a correct and intelligent solution of the various problems they must meet. They need answers to the following questions:

- "1. Is this man suffering from a compensable illness?
- "2. Was it acquired or aggravated at the last place of employment?
- "3. Does he require further treatment, or, is he able to work?
- "4. Has he suffered any permanent vital changes which will affect his future earning and working capacity?
- "5. If he dies—was the death the result of a specific occupational disease?

92. Kessler, H. H., and Coleman, B. S.: *Occupational Diseases*, American Journal of Public Health, March, 1928, pp. 271-272.

"The task of the arbitrator or medical examiner is therefore fivefold. He must do the following:

- "1. Make a diagnosis.
- "2. Determine the responsibility for the occupational disease if it exists.
- "3. Decide the temporary period of disability.
- "4. Determine the permanent disability.
- "5. Determine the cause of death."

Here again is the old difficulty of trying to reconcile medical conditions to legal interpretations, which in some cases cannot be done.⁹³ The result is that the problem is simply passed on to the physicians and, if these do not agree, the lay commissioner or court tries to guess which is right.

It is difficult to discuss the origin and persistence of such a situation without raising the question of responsibility for its existence. That responsibility must be shared by all those who assisted in formulating and administering the system. Employers, insurance companies, social workers and compensation officials had their attention so closely focused on financial and legal matters that they overlooked the medical side. This attitude seems to have been strengthened by the perhaps subconscious realization that physicians would disturb the balance of interests that had been attained. It was possibly easier for the lay interests to assume that they possessed a knowledge of medical matters than to challenge the stability of the whole balanced structure of interests by calling for expert medical opinion. A stage has now been reached at which it is almost impossible to recast the law, administrative orders and court decisions to bring them into harmony with scientifically established facts. Yet it must be recognized that all the legislatures, commissions and courts in the world cannot change those facts and that the more complex the social structure built on these legal myths, the greater the strain on all its parts.

The physicians cannot escape responsibility for this situation. At a time when their own interests, as well as the wider social ones, were at stake they were indifferent and often showed an ignorance of the social questions involved equivalent to the ignorance of medical subjects on the part of those who have written and

93. Kessler, H. H.: *Accidental Injuries*, p. 27.

administered compensation. This lack of mutual knowledge as a basis of intelligent cooperation was responsible for most of the present difficulties.

These difficulties grow more acute as the emphasis is shifted from financial to medical care—from tiding over an economic crisis to restoring the physical and economic ability of the accident victim.

The large proportion of those actually injured who receive only medical care has already been noticed. Of those who do receive financial relief, the overwhelming majority are far more interested in physical recovery than financial relief, although both are so absolutely essential that discrimination is difficult.

A further analysis of accident statistics throws additional light on the relative importance of medical and financial benefit. Compensation beneficiaries are everywhere classified according to their disability, as permanent or temporary. While the extent of the permanent disability depends to a large degree on the medical care given, and in many cases the difference between permanent and temporary may be a question of such care, these points may be waived and it may be assumed that in case of permanent disability the most important benefit is the financial one which prevents pauperization. The temporarily disabled, on the contrary, are primarily interested in restoration to health and productivity. The financial benefit is, at the best, but a makeshift to tide over the period of disability. The cash paid is seldom more than half the wages that can be earned. The maximum rate is $66\frac{2}{3}$ per cent of wages, except in Wisconsin, where it is 70 per cent, and these rates are further restricted by maximum provisions as to the rate of wages that may be used as a base of calculating benefits.⁹⁴

For the temporarily disabled worker, therefore, the character of the medical care becomes of primary importance. He needs a physician in whose professional ability he is willing to trust and who has sufficient interest in his personal welfare to hasten his restoration and protect his interests while so doing.

The United States Bureau of Labor collects very accurate statistics from a large number of cooperating industries in various lines of industry. These have been

⁹⁴ Bulletin 541, Bureau of Labor Statistics, Handbook of Labor Statistics, 1931, pp. 901-906, contains a description of benefits by states.

collected so carefully over so long a period that they are generally accepted as a fair sampling.⁹⁵

During the four years 1926-1929 inclusive there were 86,588 such nonfatal accidents classified as producing either permanent or temporary disability. Of these, 82,538 were temporary and 4,050 permanent. This would indicate that over 95 per cent of the injured received their greatest benefit from the medical care which restored them to physical soundness and industrial productivity.

The very small percentage of accidents with sufficient severity to cause a disability in excess of the "waiting period," and which are therefore unaffected by the financial provisions of compensation, but which do receive medical benefit, have already been noted. This whole point deserves the emphasis of another citation of similar statistics on this point taken from a different source. H. W. Heinrich, assistant superintendent of the Travelers' Insurance Company, estimates that there are 90,000,000 industrial injuries in the United States annually, of which only 3,000,000 are of sufficient severity to require cash compensation. The other 87,000,000 receive only medical attention and produce an average loss, according to his estimate, of \$2 each.⁹⁶

Without unduly stressing the significance of these figures, or without overlooking the natural tendency to emphasize the dramatic character of serious, and to neglect minor injuries, it still seems a safe conclusion that a disproportionate amount of influence has been exerted on the compensation problem by the less than 5 per cent of compensable accidents and then, in turn, by the 5 per cent of these in which the financial benefit dominates.

It is not surprising, therefore, that these carriers seek first to confine the selection of physicians in compensation work to those whose judgments in regard to financial payments shall be favorable to the carriers, and, secondly, to reduce the payments for medical care as low as possible.

The distorted emphasis placed on the financial phases may have been partially responsible for delay in carry-

95. Handbook of Labor Statistics, Bulletin 541, U. S. Bureau of Labor Statistics, September, 1931, p. 297.

96. Handbook of Labor Statistics, Bulletin 541, U. S. Bureau of Labor Statistics, September, 1931, p. 315. No distinction is made between medical and other sources of loss, which include lost time and delay in production.

ing through the program of physical restoration by a definite program of rehabilitation. It was not until April 10, 1919, that the first state, "New Jersey, felt that it was good business to refit its physically handicapped, just as big corporations think it is good business to salvage their waste products and make them bring in a return."⁹⁷ The federal rehabilitation law, providing for national contributions to meet the expense of states undertaking such work, became a law the next year and has been accepted by forty-four states.

This completes the program of the continuous treatment of the injured worker as an individual, with the object of, first, protection from accident hazard, second, treatment after injury, and, finally, rehabilitation and restoration to a place in productive industry. Without swinging to the other extreme and belittling the necessity of the legal, financial and educational phases of such a plan, it should become evident that the tendency is for the physician to become the most important figure throughout the system.

Unfortunately, as at every other stage in the development of this plan, organized medicine stood back and waited for legislators, inspired by educators, philanthropists, personnel workers and other nonmedical bodies to inaugurate rehabilitation and determine the form of its institutions and the methods of its administration. Yet every step in the process of rehabilitation from the diagnosis to determining the capacity of the injured to profit by rehabilitation treatment, including the character of that treatment and the adjustment of prosthetic appliances, to the final certification of the degree of restoration which has been accomplished, must be taken under medical guidance.⁹⁸

In spite of this dominant importance of medical care, the indifference of the physicians and the activity of other interests so stamped the nonmedical pattern on the administration of the federal rehabilitation act that the Federal Board for Vocational Education, entrusted with the administration of the act, replied to the question, "May federal funds, or funds to match federal funds, be used for medical care necessary to mental and physical restoration?" with the following answer:⁹⁹

97. Kessler, H. H.: *Accidental Injuries*, p. 663.

98. Kessler, H. H.: *Accidental Injuries*, pp. 284-285, 670, 677.

99. *Rehabilitation—A Statement of Policies*, Bulletin 57, Federal Board for Vocational Education, September, 1920, p. 31.

"No. The law explicitly states that its purpose is 'to provide for the promotion of vocational rehabilitation of disabled persons.' The Board interprets the term 'vocational rehabilitation' as used in this act not to include the work of physical rehabilitation, although such work may be a necessary preliminary to or accompaniment of vocational rehabilitation."

The same authority outlines the details of "case procedure" in rehabilitation work with no reference to the work of physicians, except to say: ¹⁰⁰

"Physical rehabilitation is that part of rehabilitation in which the State board is vitally concerned but not actually involved. It is purely professional and may be considered as that part of rehabilitation carried out by the medical profession beginning at the time of injury or onset of disease and continuing until the patient is physically capable of profiting by some form of vocational training leading up to the employment objective."

When the actual work of one of the most successful rehabilitation clinics in the United States is analyzed, the following results are found: ¹⁰¹

"Of the 7,683 cases treated in the past year, 6,433 were restored to their jobs without intervention of the vocational director. This job restoration was accomplished after varying periods of treatment: 5,250 cases after three months; 727 after six months; and 656 after nine months; while 1,251 cases were turned over to the vocational director for training and placement as they were unable to make job restoration themselves."

Without in any way disparaging the function of other factors in the field of compensation, it seems to be a very conservative conclusion that the neglect of the medical factor in the early stages has handicapped all the workings of compensation, and that one of the most pronounced features of the evolution of compensation has been the increased recognition of the importance of the medical factor at every stage.

100. Industrial Rehabilitation—General Administration and Case Procedure, Bulletin 64, Federal Board for Vocational Education, March, 1921, p. 10.

101. Kessler, H. H.: Rehabilitation of the Physically Handicapped, Journal of the Medical Society of New Jersey, February, 1928, p. 90.

CHAPTER V

CHOICE OF PHYSICIANS

No question has aroused more bitter discussion in the field of compensation than that of the right of the injured employee to choose the physician that shall treat him. With the exception of a very few states, to be later considered, compensation laws provide, either directly or by inference, that the employer shall furnish medical care in case of accident. This clause has been held to involve the right of the employer to select the physician or surgeon who shall do the work. The employer then generally assigns this right to the carrier with whom he insures.

It has always been a fundamental principle of medical ethics that the patient must seek the physician he prefers and that his choice must not be influenced by any considerations other than the character of the treatment desired. Like every other far reaching principle, this one is constantly violated in detail. Other considerations do enter into the choice but usually only in a temporary and individual way that does not, in the long run, and throughout the profession, destroy the effect of the principle.

Professional opposition is especially strong to any solicitation or advertising or financial pressure in the interest of any individual or group of physicians to influence the choice of the patient. This attitude is not peculiar to physicians but is common to all the professions and is maintained by professional organizations in every country. The International Medical Association,¹⁰² composed of national medical societies of nearly all modern nations, in its resolutions regarding sickness insurance, which presents many of the same problems as compensation, says:

"One of the principal factors in a cure is mutual confidence between the patient and his doctor. This implies free choice of the doctor by the patient. The Association therefore demands, as an essential condition of the satisfactory working of the medical service in sickness insurance, that freedom of choice be guaranteed by the legislation of all countries."

102. *Revue Internationale de Médecine Professionnelle et Sociale*, November, 1928, pp. 67-70.

Advocates of social change cannot afford to flaunt so unanimous an opinion of those who may be presumed best qualified to judge the facts on which that opinion is based. Certainly these traditionally established relations of patient and practitioner should not be cast aside carelessly without at least an inquiry as to whether such rejection is necessary. To be specific, it is pertinent to inquire whether such a destruction of values is essential to compensation and in the interest of the employees for whom compensation is established.

What are the actual values to society and to the patient in the long established relations of private practice based on individual selection of the physician? The first is undoubtedly the confidence in the physician by the patient, the value of which in contributing to mental and physical recovery cannot well be denied. Neither can the further conclusion be denied that this confidence rests in large part on the ability to choose the physician who the patient believes will be whole heartedly devoted to his interests. That confidence will certainly be weakened, if not destroyed, if the patient is compelled to accept a physician whose professional attitude is influenced by allegiance to interests that at some points are hostile to the desires of the patient. Confidence is a matter of faith and belief rather than of reason and facts and is not to be created by protestations or even proof of superiority in the person distrusted.

Professional opinion in all lines, and not simply in the medical field, has become convinced by ages of experience that professional excellence is best tested by fair competition in a field of equally qualified competitors. To secure the best conditions for this test, professions have long excluded the incompetent by standards of admission and then insisted that further preference among those chosen depend on ability to convince patrons, by works and personality, of any individual superiority.

This socially tested process of selection and consequent encouragement of professional excellence is interfered with and partially nullified if preference is based on any other standard than professional qualifications. Compulsory selection, based on other standards, is in the nature of bribing the jury on whose multitudinous and continuous verdicts the profession must depend for those awards that are the primary incentives to professional progress. The achievements due to that progress

are among the greatest of our civilization. If unanimous professional opinion is even partially right in holding that there is a close and causal connection between this constant free choice and professional progress, then any step that substitutes financial considerations for that free choice may destroy great social values that will be hard to replace.

When freedom of individual choice by patients is destroyed, it is always to substitute some other form of choice. In the case of compensation, the traditional process is reversed. Instead of the individual patient choosing the individual physician whom he prefers, an employer or insurance carrier chooses a physician for a whole group of employees. Note that the person or institution (usually the latter) which makes the decision is not choosing some one to care for its own ills. The choice is made by a third party, which is generally a corporation—impersonal, and therefore not possessing those personal qualities of so great importance in determining relations between patient and practitioner. Moreover, the courts have frequently decided that the primary, and many decisions infer the only, purpose of a corporation is to conserve the financial interests of its stockholders.

Far-reaching and fundamental alterations in social and professional values follow from the character of this change. Lawyers, architects, artists, teachers, writers and all other members of professions have strenuously resisted all analogous changes affecting their professions as destructive of the social values which it is the function of such professions to protect. Lawyers have had sufficient power to prevent any important intrusion of corporations or other impersonal institutions into the personal relations of client and attorney. Other professions strenuously protest such intrusion and are unanimous in condemnation of its evil effects. Yet in none of these professions are the personal relations so close as in the field of healing, and certainly in no other field does the result of these relations have so great an effect on the desired outcome.

Furthermore the choice, when made by a third impersonal party, as in compensation, is not made for an individual but for a group. Here we are touching on the influence of great social tendencies and their cyclic swing. At the period when compensation institutions were taking form, popular thought had not yet recov-

ered from the tendency, arising out of the glorification of mass production in industry, to apply the same mass methods to all fields of social action. It was the period when crime and insanity were treated almost exclusively by mass confinement in prisons and asylums, when mass education was most popular and when the adequacy of mass treatment of poverty by alms and poorhouses was only just beginning to be questioned. It was the time of which Tennyson wrote when "The individual withers and the world is more and more."

Since that time the pendulum in the whole field of human relations has been, with steadily accelerating motion, swinging toward consideration of individual relations. In criminology, psychiatry, education, and especially in social work, there has come an almost universal recognition of the superiority of continuous individual, personal, "case work" over mass action. Medical relations showed more resistance than other fields of social action in yielding to this pressure for industrialization and are only beginning to come under this now almost discarded fetish of mass action. It really does not seem necessary that the healing profession should be compelled to repeat all the mistakes made by its fellow professions in order finally to arrive at that recognition of the value of individual personal treatment which it has always possessed.

There was certainly no urgent necessity for making this experiment in administering compensation. The fact that the choice of physician was handed over to the employers and then generally transferred to the insurance carriers is due to a lack of intelligent activity by the medical profession in the formative stages. So far as can be judged from contemporary discussions, so little attention was paid to the whole subject of medical care that the question of the choice of physician was not even raised before the enactment of the first laws. It was taken for granted that such slight medical care as was prescribed would be given by the same practicing physicians as were accustomed to care for the workers now brought under the law. But there was an almost uniform clause in compensation laws, to which reference has already been made, which read: "the employer shall furnish such reasonable surgical, medical and hospital services and medicine" as the law might prescribe.

The employers and insurance carriers considered that the main function of the physician was to determine the extent of disability and consequent amount of cash compensation, and quickly realized the advantage of controlling the physician who performed this function.¹⁰³

The attending physician influences the amount of compensation in two ways. He can send the employee back to work as early as possible, perhaps permitting economic pressure to overrule his professional judgment, or he can make reports and give testimony before commissions and courts which minimize the extent of disability.

Evidence that these motives have and do still influence the decisions of physicians chosen by employers and carriers is so voluminous and convincing as to make ridiculous the constant denial of such influence by representatives of insurance companies. This evidence comes from legislative investigations, official reports of various kinds, medical observers, compensation commissions, social service writers, representatives of labor, and many impartial observers.¹⁰⁴ It affords ample proof that in every state where the choice of physicians has been confined to employers and carriers there are far more and worse abuses than should normally be expected from the volume of medical treatment. There are examples, by no means isolated, of insufficient treatment, of accident victims pushed back to work before proper recovery and everywhere a vast number of examples of reports and testimony by physicians chosen by the carriers so biased as to be a source of constant

103. "In the Workmen's Compensation Act something has been introduced that is most unfortunate, and that is taking away from the patient the liberty of choice of his doctor. The Workmen's Compensation Act is splendid; it is all right; but in its framing we didn't have the foresight of the actual working of all its provisions. The practical way that it works out is that one or two men in a community are permitted or perhaps almost compelled to treat a large number of injuries that take cases away from individual practitioners. That is wrong. That was not the intent of the law, and it must be cured."—Hazzard, W. D.: *A. M. A. Bulletin*, January, 1925, p. 6. See also Lawrence, Joseph S.: *New York State Journal of Medicine*, Feb. 1, 1930, pp. 136-139.

104. Woodward, W. C.: *The State Association and Workmen's Compensation*, *A. M. A. Bulletin*, January, 1925, p. 23, et. seq. This address with succeeding discussion is a full treatment of the question of choice of physician from the medical point of view. Wilcox, Fred M.: *Medical Care and Cost*, *Bulletin* 511, U. S. Bureau of Labor statistics, April, 1930. Cochrane, Cornelius: *Meeting a Compensation Problem*, *American Labor Legislation Review*, December, 1930, pp. 433-435. Williamson, E. W.: *Symposium and Surveys*, *American College of Surgeons*, 1929, pp. 49-51. Weber, Henry C.: *Presidential Address*, *Journal Oklahoma State Medical Association*, June, 1931. Lescobier, D. D.: *Bulletin U. S. Bureau of Labor Statistics*, May, 1917; *ibid.*, February, 1926, pp. 116, et seq. Cullman Report, New York, 1932, *passim*.

complaint by commissions. An illustration of this bias is given by Fred M. Wilcox¹⁰⁵ of the Wisconsin commission:

"The right of selection has led the employer and insurer to expect, and all too many physicians to admit, that the relationship calls for aid in establishment of disability at a minimum. They give advice to the employer and insurer at the end of the treatment respecting extent of disability, and withhold this information from the employee for no sufficient cause. They inquire into the personal affairs of the injured man, into his other physical ailments, and then relay this information to the employer and insurer with a zest that betrays unmistakable partisanship. They deny the employee access to the hospital records for no better reason than the false notion that their responsibility beyond the treatment of the man is to the employer who pays them."

This conflict between financial and therapeutic motives cannot fail to influence the actions of the attending physician. If he puts his scientific and professional honor above his allegiance to the insurance company, he soon finds that he is no longer among those "chosen" to receive compensation business. The bad effects of such a conflict on patient and physician might have been forecast without waiting for the proof that is now so abundant.

The injured worker is well aware of this conflict and, indeed, is apt to exaggerate it. His thoughts are also fixed on the decision in regard to compensation and he fears that his hopes will be thwarted by the physician who is attending him. His description of his symptoms will be warped by his belief that he must guard against a suspected financial antagonism on the part of the physician. Without taking any sides in the merits of this financial controversy, it should certainly be recognized that the whole situation is thoroughly destructive of those confidential relations on which much of the success of the healing process depends.¹⁰⁶

"The doctors who treat compensation injuries work in a legal and business atmosphere where there is a constant dis-

105. Wilcox, Fred M.: Address 16th Annual Meeting International Association Accident Boards and Commissions, Bulletin U. S. Bureau of Labor Statistics, April, 1930; also in Wisconsin Medical Journal, April, 1930, p. 236; West Virginia Medical Journal, February, 1932, p. 68; Journal Tennessee State Medical Association, January 1925, p. 293.

106. Williamson, E. W.: American College of Surgeons, Symposium and Surveys, 1929, p. 50.

cussion of medical bills, compensation awards, and schedule losses. Many physicians have succumbed to the commercial influences and devote too much time and energy to thinking in terms of dollars and schedule losses rather than along the lines of scientific medicine. There is keen competition among the compensation doctors in the industrial sections of the city. Many physicians resort to various and sundry methods to secure cases for treatment. Sign-posting has become a common practice which presents an advertising aspect as well as artful deception. Finally the most inexcusable act of all is shown in some medical testimony where there has been an over anxiety to gain the point in question, even to the extent of perjury."

That this financial struggle over the accident victim leads to "shameful conditions" was the consensus of "hospital presidents, physicians and representatives of industrial commissions" at a meeting held in New York City, July 9, 1930:¹⁰⁷

"Several hospital heads, who wished their names withheld, explained that they had been frequently criticized by insurance companies because they refused to permit the removal of a patient from a hospital sickbed to an insurance clinic, deeming such removal harmful to the patient. In other cases, in which such removals were made, it was later discovered by the hospital authorities that an amputation had been performed 'because that was cheaper than keeping a worker from his job in a sickbed long enough for a complete medical cure.'"

The generally corrupting influence that follows the injection of organized financial motives into a set of medical relations based on the physician seeking the patient, thus turning the foundation of medical ethics upside down, is graphically described in the report of an official investigation¹⁰⁸ of the New York compensation situation:

"But if the desire to write insurance makes certain carriers blind to peccadillos, the desire to secure the medical business makes the doctors unable to see clearly. The rewards are so great that doctors compete with each other for business. Many of them advertise; many of them pay commissions or give other considerations for business sent to them. In the past instances have not been infrequent of doctors splitting fees with the insurance company adjusters who assigned the cases

107. Pennsylvania Medical Journal, October, 1930, p. 52.

108. Rogers, Lindsay: Investigation of Administration of Department of Labor, 1928, New York Legislative Document, 152 Session, Volume 18, No. 49, p. 131.

for treatment. Insurance company medical directors who are surgeons send injured workmen to practitioners, who refer their private patients in need of surgical care to the insurance surgeons for operations. Reciprocal back-scratching is very prevalent. The solicitations used affect the stomach as well. The medical director for one large insurance company tells me that his most difficult problem is with physicians who use liquor prescriptions to bribe foremen of manufacturing establishments. The foremen are thus persuaded to send their injured workmen to the physicians who furnish the prescriptions, and to authorize those physicians to give the necessary treatments. A physician who would secure business in this fashion, it hardly needs to be suggested, is probably not competent in traumatic surgery. . . .

"Doctors or groups of doctors who have considerable practice can afford to spend large amounts on solicitors of business and on agents who lift cases from other doctors. It would be interesting to examine the records of some of the principal specialists who possess large incomes, and to see what percentages are spent for such solicitation. The insurance companies might find that as much as one-quarter or one-third of the fee for treatment goes for the expenses which physicians incur in competing for shares of the \$8,000,000 annually dispensed for medical care under the Workmen's Compensation Law."

The arguments in favor of confining the choice of physicians to employers and carriers say little of the financial issues involved save in the way of references to suspected malingering and claims that physicians selected by injured employees present excessive bills for services, against both of which evils the carriers have ample protection from other directions.

The argument most frequently utilized before legislative, administrative and judicial bodies is that since the employer pays the bills, he, or the carrier as his representative, should have the right to choose the physician to whom the money is to be paid. It is hard to see by what process of legal logic this reasoning is maintained. No theory of compensation yet propounded claims that the money for compensation of injured workmen belongs after collection to employers or insurance companies. All these theories hold that it is the property of the accident victims. Nor, if the most commonly accepted theory of compensation is correct, is it even paid by the employer, but instead by the consumer, from whom it is collected by the

employer, as part of the costs of business.¹⁰⁹ Such money constitutes a trust fund to be administered and distributed, in accordance with the law, to injured workers. To direct any part of its distribution to the protection of employers or insurance companies to be used in defeating their legal responsibilities to those injured workers is essentially a betrayal of trust.

The second argument against permitting the patient to choose his own physician rests on a claim which, if it can be substantiated, deserves far more consideration. This is the claim that the specialized industrial service supplied by the carriers is superior to that offered by the private practitioner who might be selected by the individual worker. This claim is supported by the argument that it is to the interest of the employer and carrier to reduce as much as possible the extent of the disability for which cash compensation must be paid. Therefore, it is to the interest of the companies to provide the very best and most highly skilled care possible, and when such care is made available it is not fair for the employee to be permitted to reject such care in favor of perhaps inferior service which will prolong his disability and penalize the companies with the resulting increased compensation.

In support of this position, the companies point to the extensive medical equipment they have assembled, often staffed with highly skilled specialists in traumatic and orthopedic surgery. That many such high grade medical departments do exist and have made valuable contributions to industrial surgery and medicine it would be unfair to overlook; but that all medical services maintained by employers and insurance companies are of this superior character the evidence just cited, with much more available, is ample to disprove. In fact, wherever any comprehensive investigation of the medical service furnished by insurance carriers has been made, it is the general conclusion that price rather than quality of service has been the criterion by which the medical staff has been selected.¹¹⁰

The research Committee on Traumatic Surgery, appointed by the Board of Regents of the American

109. Harry Gunnison Brown in "The Economics of Taxation," 1924, pp. 162-163, argues that the nature of the imposition of compensation premiums according to pay-roll is such that "their only effect is to reduce wages," and that, therefore, the burden falls on employees.

110. Report of Jeremiah F. Connor, Moreland Act Commission, New York Legislative Document 74, May 27, 1919, pp. 15-33 et passim.

College of Surgeons, in a report made in October, 1926, says:¹¹¹

"While there is a very definite trend on the part of carriers of Workmen's Compensation insurance to obtain more experienced surgeons, our review indicates that generally traumatic injuries have not been cared for by the better qualified in surgery."

Types of medical care do not lend themselves readily to accurate statistical comparisons of results. There are so many unknown features, quantities involving factors not susceptible to comparison, and so many variable human elements involved as to render such comparisons very unreliable. Dr. Roscoe N. Gray,¹¹² medical referee of the Aetna Life Insurance Company, has made a comparative study based on 34,753 compensation files from northern California. The study was made with the definite object of guiding the claim examiners in deciding which patients should be brought to San Francisco or other large city for specialist treatment and which ones should be left with their own medical advisers. Manifestly the study does not offer a full and fair test on the point of choice of physicians, but as the only study bearing even indirectly on the problem it deserves consideration.

He found that in serious fractures of the femur "the country disability was nearly three times the city disability, and over four times the San Francisco disability."

"In the bones of lesser importance, the fracture specialist has not made a very good showing. The period of disability with fracture of the fingers has been greater under his care than with the general surgeon. In fact, the country doctor was the most efficient."

Fractures of the metatarsus and metacarpus showed little difference. Operative cases with open treatment showed considerable superiority on the part of the specialists.

"Now we come to the great intermediate group of fractures, which are either treated by a fracture specialist, or a general surgeon, depending upon the severity of the individual case. With the radius and ulna combined, the general surgeon made as good a record as the specially trained surgeon.

¹¹¹ Rogers, Lindsay: Investigation of Administration of Department of Labor, 1928, p. 132.

¹¹² Gray, Roscoe N.: Journal of Bone and Joint Surgery, January, 1928, pp. 27-39. See also p. 87.

"In the treatment of these bones separately, the general surgeon closed his treatment even sooner. In San Francisco most of the fractures of the radius were treated by a fracture specialist from the start, with an average disability of six weeks. The country surgeon obtained as good a result with less than half the medical cost.

"This is generally true throughout the fractures of intermediate importance. Thus one is forced to the conclusion that the specialist does not always reduce disability, even with the added cost of his services. When one reviews the individual files, the reason is clear. The general surgeon or practitioner is closer to the human side of the practice of medicine. He subconsciously is always trying hard to relieve his patients of expense, though he sometimes uses too few of the accessories of medical science, or discharges the patient from treatment too early. It is not at all rare that a general surgeon treats a fracture throughout without even taking an x-ray picture. Such a procedure is obviously fraught with danger. The fracture specialist goes to the other extreme. He considers his patients' welfare without regard for time and money. He therefore has but few recurrences. His patients usually stay at work when he sends them there. But sometimes he goes too far, and in average groups of less important fractures, the general surgeon conserves more time and money than the specially trained surgeon."

It seems a fair conclusion to say that the study proved some superiority of the specialist in the small minority of serious and complicated fractures requiring hospital treatment, but that in the vast majority of more minor injuries the practitioner who was "closer to the human side of the practice of medicine" produced the best results.

The various elements involved in this question are most fairly and adequately summed up in a decision of the Connecticut Board of Compensation Commissioners:¹¹³

"Much complaint is made, and in many cases justly, by insurers and employers because they are imposed upon by injured employees who have reached a stage where it is impossible to tell whether they are malingering or suffering from a genuine psychosis. I am wondering, however, if surgeons who are habitually treating injured workmen for insurers do not themselves sometimes acquire a form of suspicion psychosis. I think this woman would be much further advanced on her road to recovery at the present time if the symptoms she

113. Memo. of Commissioner in *Jennie Riddell v. C. Fox & Co., Aetna Life Insurance Company*, Nov. 24, 1928, *Connecticut Workmen's Compensation Digest*, vol. V, pp. 446-447.

described had been taken more seriously and she had not been irritated by numerous efforts to get her back to work.

"While she has been treated successively in the past by a highly skilled general surgeon, and later by a highly skilled orthopedic surgeon, who also consulted with a second orthopedic surgeon of high standing, I have passed with an order directing that until further notice she be treated by another orthopedic surgeon in whom she has confidence. This ought to be a factor in hastening her recovery. It is unfortunate when an injured employee of a nervous temperament gets the impression, however unjustly, that the physician treating him is working in the interest of the insurance company or employer. The mental and the physical are so intimately connected that one of the prerequisites of a proper exercise of the healing art is complete confidence between the physician and the patient. On the whole, an average higher grade of medical, surgical and hospital service is, in my opinion, secured under the Connecticut Act under which the employer or the insured has the right to designate the surgeon, than would be secured if the employee selected his own surgeon. Both humanity and enlightened self-interest require that the insurer and employer select from the most skilled and reputable physicians and surgeons of the community, and this was true in the case at bar, and is generally the case; but if these cases cannot be handled in such a manner as to inspire confidence on the part of workmen, some modification of the present system may naturally be looked for in the course of time."

The evidence on this point is so slight that it is worth while to quote the observation of H. W. Albertson¹¹⁴ of Pennsylvania at the Tri State Medical Conference, embracing New York, Pennsylvania and New Jersey:

"Recently I talked with the manager of the compensation fund in Scranton. The State Insurance Fund has certain districts in which it works and a man is appointed to supervise each district. I said to him: 'You insure groups of employees and the employer selects the physician. Other groups of people have a choice in selecting their own physicians. What is your experience in the relative length of disability in those two groups?' He said there was no difference."

This observation is confirmed by some additional facts. In Massachusetts, Rhode Island and North Dakota, from the beginning of compensation, the employee has had the right to choose his own physician. In several other states, active cooperation by the

114. Pennsylvania Medical Journal, June, 1931, p. 657.

medical profession has secured the removal of most of the limitations on such choice. The remarkable fact is that a diligent search of the large volume of material issued by the insurance companies in opposition to free choice, and depicting the evils that are supposed to follow such freedom, has failed to find a single citation even claiming that any such evils have arisen in the states mentioned. If any such evils did exist, it would seem that they would certainly have been cited with sufficient frequency to attract attention.

There is another side to this question of the comparative quality of the service which is seldom considered. No one proposes to prevent any injured worker from choosing the company service. If it really is so superior it will be so recognized and chosen. The fact that the companies object to freedom of choice may sometimes be due to the difficulty of proving its superiority, and the fear that a potential freedom of choice will compel higher and more expensive standards.

This whole point has been so well stated by W. C. Woodward¹¹⁵ that it is far better to quote him directly than to attempt an independent argument:

"Presumably the workman who has freedom of choice will procure the best medical service available, and no one has ever yet proposed that, in the exercise of his right to choose, the workman shall be debarred from choosing any medical service the employer may provide. The employer, then, who insists that the workman shall not be given freedom of choice is in the position of contending: (1) that the workman is willing to submit himself knowingly to inferior medical treatment in order to obtain the services of a physician who he believes is not biased in favor of the employer; (2) that the workman is too stupid to choose the best service even when it is placed before him, or, (3) that the service offered by the employer is not the best, but must be forced by law on the unwilling employee. As a matter of fact, to allow injured workmen to choose between the medical service offered by an employer and the medical service obtainable elsewhere should stimulate a healthy competition for excellence of service in the plant and among competing physicians, and thus result in the maintenance of the highest possible grade of professional services in the community. . . .

"The injuries that arise out of the industry are being treated in all parts of the country under all possible conditions. The physicians who treat them are ordinarily the physicians who

115. Woodward, W. C.: A. M. A. Bulletin, January, 1925.

are practicing in the community and who depend on the community for their medical and surgical resources, just as their associates do. To infer that because a physician in a community has been selected by some local manager, or division or camp boss, to treat his injured employers he is or thereby becomes better qualified to do such work than are his associates in the community, would require a considerable stretch of the imagination."

Medical societies everywhere have been insistent on the evils of forcing the services of a physician on an objecting patient.¹¹⁶

They have worked continuously for modification of the law giving an outside party power to control a monopolized medical service. In many instances this attitude of the physicians has been supported by organized labor. The defenders of enforced choice on a financial basis have been the insurance companies.¹¹⁷ In this position they have usually been supported by the physicians and surgeons employed by industrial plants or insurance carriers, or who were receiving much business from such organizations.

However, there are a number of tendencies which, while still too weak and indefinite to permit any important conclusions to be drawn from them, would seem to indicate that the pendulum is now swinging toward greater freedom of choice by the employee.

There is growing recognition of the fact that, even where the employee does exercise his right of choice and accepts the penalty for so doing by paying his own medical bills, the interests of the employers and carriers are well guarded. Practically every law provides that in such a case the insurance carrier or employer is entitled to send a physician to examine the patient. There are complaints that such physicians exceed their legal and ethical privileges by criticizing the service of the attending physician to the patient and thus undermining his confidence. J. G. Crownhart,¹¹⁸

116. A few of the references on this point, in addition to those already cited are: Proceedings House of Delegates, Minnesota Medical Society, Minnesota Medicine, September, 1931, pp. 848 and 659. Twitcheil, Herbert F.: President's Address, Maine Medical Journal, July, 1928, p. 117. Report Legislative Committee Tennessee State Medical Society, Journal of the Tennessee State Medical Association, January, 1925, p. 293. Resolutions of County Medical Societies, Northwest Medicine, May, 1932. Resolution Illinois State Medical Society, Illinois Medical Journal, July, 1925, pp. 22-23.

117. Bulson, Albert E., Jr.: A. M. A. Bulletin, January, 1925, pp. 25-26.

118. Crownhart, J. G.: Wisconsin Medical Journal, December, 1928, p. 574.

secretary of the State Medical Society of Wisconsin, describes such a situation:

"In these days of compensation insurance a new cause for misunderstandings between physicians exists. It is an everyday occurrence for the insurance carrier to demand that 'their physician' see the case. I have seen reports written by such physicians scoring the acts of the family physician. The insurance company may show this report to the claimant to show how his period of recovery was prolonged by faults of the family physician explaining that the company could hardly be expected to pay for that period."

The company can also ask for an examination by the medical examiners of the compensation commission and can present all of this evidence to the commission in a hearing to determine the charges for medical service.

The steady pressure of the medical societies and the continuous exposure of the evils that arose from the third party selection of physicians, backed up by the demands of the employees, caused California and Wisconsin to introduce a "panel system," which requires the carriers to designate two or more physicians or surgeons in each locality from which the injured employee can choose.¹¹⁹ Complaints are still made in Wisconsin that the insurance companies seek to evade the law by confining their panel selections to members of groups of physicians closely allied with insurance practice.

In New York, negotiations between the state medical society and the compensation commission promise to remove some of the worst of the long standing evils in medical service arising out of the domination of that service by insurance carriers.¹²⁰

119. The amending section of the Wisconsin law reads as follows: "The employee shall have the right to make the choice of his attending physician from a panel of physicians to be named by the employer. Where the employer has knowledge of the injury and the necessity for treatment, his failure to tender the same shall constitute such neglect or refusal. Failure of the employer to maintain a reasonable number of competent and impartial physicians ready to undertake the treatment of the employee and to permit the employee to make choice of attendant from among them shall constitute neglect and refusal to furnish such attendance and treatment."—On California law see Pillsbury, A. J.: *Changes in the Compensation Law*, p. 13.

120. *New York State Journal of Medicine*, May 1, 1931, pp. 554-555 and April 15, 1932, pp. 482-483. See pp. 116-117.

CHAPTER VI

PAYMENT FOR MEDICAL SERVICES UNDER COMPENSATION

There has always been much sharp and continuous controversy between physicians and insurance carriers over the proper payment for services. This arises out of the fact that such payments form by far the largest flexible expenditures in the system. Cash compensation is usually fixed by schedules written into the law and offers little opportunity for bargaining. The direct commissions which may be collected for insurance are also fixed at a point that is supposed to cover only the expense of securing and conducting the business. Any surplus obtained by the carrier must come largely from ability to keep the expense of medical care below the level at which it was estimated for the purpose of fixing rates and through the selection of risks, accident prevention and adjustment of schedule and experience variations.

The first laws fixed limits, both as to length of treatment and as to payments, so low that any sort of adequate medical care exhausted this limit so frequently that there was little margin. When the medical limits were raised or made unlimited there was a wide margin of judgment as to what is necessary and what should be paid for such care. The insurance carriers have opposed every increase in medical benefits. They were largely responsible for the long waiting periods and totally inadequate time and money benefits in the early legislation. The attitude of the companies on this whole question of medical care in compensation was stated quite frankly in an address by Edwin S. Lott, president of the U. S. Casualty Company, delivered before the Insurance Society of New York, Oct. 22, 1912, from which the following statements are quoted:¹²¹

"Under workmen's compensation laws we are liable to divert a large part of that fund into the pockets of doctors instead of lawyers—we are going to create the 'ambulance chasing doctor.'
. . . .

121. From report published by Travelers' Insurance Company.

"Employers in this state can be legislated into paying so much and no more of their income for compensation purposes. Anything beyond that certain amount will drive them out of business or out of the state. Now if a large part of the fund which is created for compensation to injured workmen finds its way into the pockets of doctors, there will be that much less left to be paid to injured workmen and their dependents. . . .

"Wherever in this country a workmen's compensation law has a drastic medical attention feature, the cost to employers for that feature alone will be more than the cost for the weekly compensation feature—the doctors will get more than the injured workmen. . . .

"I call your attention to this because we will have before our legislature this year a workmen's compensation bill which will provide for medical, surgical and hospital treatment for injured employees at the expense of the employers. Everybody should use his influence to have a very small limit put on the amount employers shall be taxed for this service. . . . Let us not endorse any bill which will cause us to pay out a needless amount of money for medical, surgical, and hospital services. . . .

"If you can keep down the cost of medical attention you will permit insurance companies to sell workmen's compensation insurance for a good deal less money than must be charged if there is an unlimited liability as respects the doctors' bills."

Because this is a franker statement of insurance company attitude than was customarily made at a later date, some of its provisions deserve further analysis, especially as they forecast the tactics pursued up to the present. Note the repeated solicitude lest too large a part of the fund be diverted into the pockets of the doctors, which would prevent insurance companies selling "workmen's compensation insurance for a good deal less money." It should not be overlooked that some state funds have built their records for economy by similar tactics.

The implication is that the employee does not receive full value for this service—that payments for medical care constitute some sort of donation to the physicians which they have "diverted" into their own pockets. It would be foolish to deny that, whenever financial motives come in conflict with professional standards, some individuals will sacrifice those standards. The illustrations already cited of the conditions of medical service controlled by insurance carriers is sufficient evidence on that point. No one has ever claimed that if all physicians in compensation practice were free to fix their own rate of payment that there would be no

instances of excessive charges. But no such freedom has ever existed under any compensation system. The real point, which is so often overlooked in this discussion, is that medical care is a very essential part of the compensation given to the employee. It is given for his benefit and not for the benefit of the physician. That it is given him in "kind" instead of in cash, and necessarily given through the employment of a physician, does not in any way alter this fundamental fact. That medical payments go to physicians is true only in the same sense that cash payments go to the landlord, grocer or druggist.

Since this criticism of the cost of medical care almost invariably comes from the insurance companies, it inevitably suggests comparison. Stock companies, engaged in compensation insurance, are always permitted to retain at least 41 per cent of all money paid by the employer for compensation purposes. The most liberal provision for medical care has never provided for the payment of as large a share of the original premium dollar for medical services. Moreover, the experience of state funds has shown that from 5 to 10 per cent of the premium dollar is ample payment for all the services usually performed by the insurance companies that are in any way beneficial to the accident victims. The 17.5 per cent that is everywhere allowed for "acquisition costs" is wholly unnecessary in compensation where insurance is compulsory. The selling service is in no way analogous to that performed in individual life, fire and accident insurance, where, without the solicitation of the salesmen, the individual might neglect the protection. This money is truly "diverted" into the pockets of salesmen, brokers and general agents, and this for no service whatever to the employee.

This point has been stressed to the extent of repetition because the question of adequate medical care and consequent adequate payments for medical service, in practical politics, however carefully that fact may sometimes be concealed, turns on the way in which that portion of the premium dollar which remains after cash compensation has been paid is divided between payments for medical service and insurance premiums.

It has already been shown that the stock companies are permitted to retain 41.6 per cent of all money collected from the employers for compensation, and that in many states they succeed in retaining more than this

percentage. The best statistics available, which are, to be sure, none too accurate, indicate that of the remaining 58 per cent about 34 per cent goes for medical care and 66 per cent for cash compensation. This means that of every dollar collected for compensation, where the insurance is handled by stock companies, approximately 42 cents goes to the carrier, 38 cents is spent for cash compensation and 20 cents is spent for medical and hospital services.

All phases of this struggle were illustrated in an address of G. L. DeLacy and the succeeding discussion before the Omaha-Douglas County Medical Society, Jan. 8, 1929.¹²² Mr. DeLacy, after pointing out that, while the cost of cash compensation in Nebraska had increased from \$76,000 in 1916 to \$692,000 in 1927, medical expenses had grown from \$49,000 to \$300,000 in the same period, and after admitting that much of this was due to more liberal legislation, declared that "Most of the blame falls upon the doctors," owing to "the tendency upon the part of a small percentage of physicians and surgeons to purposely pad their bills and increase the medical expense."

In the discussion, a physician called attention to the fact that the average cost for medical aid in all compensation cases was \$15 and that "nearly \$600,000 was paid for the underwriting of the act, twice as much as was paid for medical, and about an equal amount paid in compensation."

This discussion with the interests represented, their attitudes, the issues involved and the arguments presented, is typical and has been duplicated in almost every compensation jurisdiction in the United States.

Another point of view of this problem of payment for medical services is gained by an examination of the situation out of which compensation arose. Before compensation, a large percentage of accident victims became indigent with the stoppage of work and were cared for as charity, without payment to the physician. Those who were able to prove liability in the courts received damages which were supposed to include their medical expenses. Recalling what has been said about the success of liability insurance companies in fighting such claims, it is not surprising that public sentiment

122. *Nebraska State Medical Journal*, February, 1929, pp. 56-63.

and resentment led the physicians involved in a liability case to charge "what the traffic would bear."

The Connecticut Compensation Commission,¹²³ in commenting on the adjustment of a disputed fee case in the early years of compensation, expressed this attitude as follows:

"Many physicians have been in the habit of treating patients who have received personal injuries subject to damages under the general law of liability and being paid what they saw fit to charge therefor by insurance companies or employers. In such cases there is, of course, no statutory limitation upon their charges and no authority except the courts to which the insurer or employer may appeal. Such physicians therefore claim to be unable to understand why insurance companies dispute their bills with regard to injuries falling under the Workmen's Compensation Act."

The great majority of cases fell rather within the first category, that of those previously treated as indigents. The effect of this situation was strengthened by the very similar wording of most compensation laws to the following effect:¹²⁴

"The pecuniary liability of the employer for such medical, surgical and hospital service herein required shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person."

Manifestly, this regulation failed to meet the situation when the standard of living of the injured persons was such that they could not pay for medical services. The first move of the insurance companies was to try to take advantage of this custom and have their accident cases treated as subjects of charity. W. C. Woodward, in the discussion previously quoted,¹¹⁹ described the dilemma in which this situation placed the physician:

"Every workmen's compensation act provides in some way for payment for treatment of injuries resulting from industrial accidents. What is too often done, however, is (1) to provide for an amount of treatment insufficient to meet the needs of the patient, or (2) to limit payment even for such as is authorized to an amount that is in many cases far below the value of the services required. The physician is thus put in a position where he must either (1) refuse to treat industrial accident cases under

123. Connecticut Workmen's Compensation Commission Digest, 1914-1916, volume 1, p. 470.

124. Indiana, Acts of 1915, chapter 106, sec. 26.

a workmen's compensation act; (2) treat any such cases only to the extent that the law has provided for compensation for his services and then, unless the employer or the patient is willing to assume liability for further treatment, to abandon the patient to charity, or (3) to treat the patient to the best of his ability, so long as treatment is needed, to accept as a partial return for services rendered the inadequate compensation allowed by law, and charge the balance as a contribution to charity. Professional tradition and personal pride compel the physician to follow the course last named, and the physician, not the employer or workman, pays the price. The industry profits to the extent of the physician's loss. The cost of industrial accidents is thus merely shifted from the industry to the medical profession, and the supposed purpose of the act is defeated. It is of this that the medical profession complains."

There has never been any relaxation of the effort to shift the cost of medical care on the physicians. When experience proved that adequate medical care reduced cash payments, carriers demanded more extensive and expensive treatment but continued to make strenuous efforts to shift the increasing costs to the physicians.

Hospitals were, and still are, the especial victims of this policy. They had long cared for injured indigents as a part of their charity work. When compensation made such care compulsory for employed workers, it supposedly provided that consumers should bear the expense; but the insurance companies tried to shift the financial burden, which they had legally assumed by collecting premiums, to the charity department of the hospitals.

During the first three years of the operation of the New Jersey law, a large proportion of the cost of medical care for compensation patients was carried by the hospitals. "One hospital, which is forbidden by its charter to charge for its services, estimated that it treated three-fourths of all the work accidents occurring in the city in which it was located."¹²⁵

When the hospitals protested these tactics and tried to secure payment for their services, they were met with determined resistance before the commissions and later in the courts. In almost every instance these bodies recognized the injustice of extending to solvent corporations the charity privileges designed for indigent individuals. In a California case in which the state

125. *Three Years Under the New Jersey Workmen's Compensation Act*, American Labor Legislation Review, March, 1915, p. 68. (This is a review of an official investigation.) See also Breakstone, Benjamin H.: *Abuse of Medical Charity*, Illinois Medical Journal, August, 1925, p. 151.

insurance fund sought to avoid payment, the commission said: ¹²⁶

"Where an employee, upon being refused treatment by the insurance carrier, obtains it from a county hospital, which, by its charter, is forbidden to receive remuneration, the insurance carrier is, nevertheless, liable for the reasonable value of such treatment, the prohibition in the charter being inapplicable under the circumstances."

In a New York case in which the carrier attempted to invoke the clause of the law which provided "for similar treatment of injured persons of a like standard of living," and it was contended that the rate of \$3 a day commonly charged was for charity cases, the court sustained a charge of \$4.50.¹²⁷

The Special Commission to Investigate the Operation of the Workmen's Compensation Law of Massachusetts, appointed in April, 1926, laid down the principle that "A hospital should not be forced to do charity in industrial cases; and the full expense of the medical care of industrial cases should fall where the expenses of compensation fall, so that both together may be included in the insurance required by the Act."¹²⁸

The extent to which Pennsylvania hospitals contributed to the cost of compensation is shown by a report of a study of 141 hospitals made by the Hospital Association of Pennsylvania.¹²⁹

"The report shows:

Compensation cases treated, Wards.....	12,465
Compensation cases treated, Accident Room.....	31,533
Compensation cases treated, Out-patient Department...	21,664
Total	65,662

"Regarding compensation cases staying more than 30 days:

Total cases	3,318
Cases in which cost exceeded \$100.....	2,064
Patient days of care furnished after 30 day limit....	7,731
Out-patient treatments furnished after 30 day limit..	59,966

126. *Bobar v. State Compensation Insurance Fund*, December, 1926. Reported in *Workmen's Compensation Bulletin*, October, 1927, p. 24.

127. *Messinger, v. Chemung Corporation*, reported in *Industrial Bulletin*, November, 1931. See also Report of Cullman Committee, Feb. 23, 1932, mimeographed copy, pp. 1 et passim.

128. *Workmen's Compensation Bulletin*, February, 1927, p. 4. See also Donoghue, Francis D.: *Medical Services and Medical and Hospital Fees Under Workmen's Compensation*, 1917.

129. *Bulletin of the American Association of Industrial P. & S.*, April, 1927, p. 4. See also *Journal of the Medical Society of New Jersey*, September, 1926, p. 475.

Cost in excess of \$100 after 30 day limit	\$207,676.05
Cost in excess of \$100 after 30 day limit paid by carriers	70,756.35
Cost in excess of \$100 after 30 day limit paid by patients	8,991.52
Net loss to 141 hospitals after legal limits had expired	130,033.43"

As a result of this report, the attorney general was asked for an opinion on the question of the payments to hospitals in compensation cases. In reply he said:¹³⁰

"In compensation cases these institutions, state hospitals, are entitled to collect from employers the cost of surgical, medical and hospital services and medicine and supplies furnished to injured employees, notwithstanding the fact that the injured employees would be entitled to free service if their cases did not come within the provisions of the Workmen's Compensation laws. This point was expressly decided by the Supreme Court of Pennsylvania in *Trustees of State Hospital v. Lehigh Valley Coal Company*, 267 Pa. 474 (1920)."

This question is one that has been the subject of sharp controversy in nearly every compensation jurisdiction and efforts are being made to work out some sort of regional standardization of hospital charges for compensation work.¹³¹

There are few states in which the sums paid to hospitals for compensation cases equal the cost of caring for such patients. The State Hospital Association of New York, after a careful investigation, found that the cost of adequate care exceeded \$5.50 a day but agreed to accept that amount. But the carriers have always been able to force a lower rate, so that those hospitals which gave proper care have been compelled to draw on their endowment funds and increase the charges to pay patients in order to meet the deficit.¹³²

In Oregon, similar studies showed a per diem cost of \$3.50 and a payment of \$2. It might be well to call attention to these facts as accounting for some of the "high hospital costs" to pay patients, who are by this method compelled to contribute to insurance carriers a part of the cost of caring for compensation patients.

130. West Virginia Medical Journal, November, 1928, p. 563-564. The full opinion covers a number of points and cites the cases applying.

131. Lewinski-Corwin, E. H.: Standards of Hospital Care, Modern Hospital, January, 1927, p. 64.

132. Bulletin American Hospital Association, January, 1932, p. 9. Letter from Homer Wickenden, director, United Hospital Fund of New York, to William Cavanaugh, manager, claim Department, National Bureau of Casualty and Surety Underwriters, who supplied copy. See also Journal Oklahoma State Medical Association, January, 1925, p. 11.

In hospitalization, as in home treatment, compensation cases require much attention and involve a number of relations not found in treatment of other patients. These peculiarities and accompanying difficulties have been set forth as follows: ¹³³

"Other unsatisfactory aspects of handling compensation cases from the standpoint of the hospital are: (1) the additional work of preparing form reports as required by law; (2) 'lifting cases'; (3) difficulty in collecting accounts for numerous reasons; (4) frequent subpoena of records (one hospital reported that one man is employed almost full time to carry records to the various hearings in the city); (5) large amount of time required to answer inquiries by telephone and letter from claim departments and medical departments of Insurance Companies, from the Workmen's Compensation Bureau, from lawyers, runners and others; (6) problems of discharging convalescent cases. There are many cases having been hospitalized for an extended period that reach the stage of maximum benefit from hospital treatment and are ordered discharged by the attending physician and the carrier concludes payment for hospital care. The patient may be a laborer who lives in a third floor rooming house and is unable to care for himself. The hospital is obliged to retain the patient until he can carry on alone. This situation is the basis for a very important subject—namely, the need of convalescent hospitals. (7) Difficulties with authorizations for treatment—injured employees are often brought to the hospital in a rush without authorization having been procured from the employer. The hospital provides treatment and attempts to secure the necessary credentials later, but it encounters delays, questions, objections, and sometimes failure. The carrier may stand on his rights and not pay the bill until proper authorization is secured. (8) In 'third party cases,' which usually extend over a long period of time before settlement, the hospital is unable to collect for services until the case is finally settled. These accounts often represent large sums which in some cases the hospital never collects. (9) Failure on the part of the surgical service to cooperate with the hospital administration.

"While hospitals have recited the undesirable features of compensation practice existing at present they have not been unmindful of the benefits which they derive from the care of the injured. One hospital superintendent enumerates the following advantage: (1) Compensation cases occupy ward beds that otherwise may be vacant. While the income is not quite equal to per capita cost it may be regarded as additional revenue to the hospital which amounts to a worthwhile income. (2) Compensation cases provide a fairly uniform and dependable supply of ward patients for desirable intern and staff service."

133. Williamson, E. W.: American College of Surgeons Report, Symposium and Surveys, 1929, pp. 52-53.

The conflict as to medical costs ultimately focused on the fees charged by individual physicians. It was always complicated by the question of free choice of doctor and the existence of various forms of contract practice. In the beginning, compensation cases were usually treated by physicians as ordinary patients and bills were rendered to the insurance carriers or employers. If the latter objected to the amount charged, an appeal was taken to the industrial commission, court or other body authorized to adjudicate compensation payments. A majority of such bodies either have some sort of medical department, or adviser, or impartial medical referees, whose advice is usually asked as to the reasonableness of the charge. The standard applied in such decisions is that "the charge should be based upon the patient's standard of living and determined as if the treatment were to be paid for by himself."¹³⁴ In fixing the charge, the absence of risk of nonpayment is also taken into consideration, a point of some importance in its subsequent effect on the fixing of fee schedules.

Such schedules have been established in many states. In some they have been formed by legislative action, which has involved a political struggle. In Nebraska, when a new fee schedule was under consideration the Manufacturers' Association and the carriers fought to keep fees down¹³⁵ and the same story can be duplicated at every session of every legislature where legal fee schedules are considered.

Much more satisfactory results are obtained when the commission, or other body administering the law, develops a fee schedule in cooperation with representatives of organized medicine. In some instances, representatives of the insurance carriers are also invited and an effort is made to agree on a suitable schedule. In other cases, the carriers and the medical profession make their arrangements and the result is accepted by the commission.¹³⁶

A study of the fee schedules now in operation in the various states, and replies received to a questionnaire

134. National Industrial Conference Board: *Workmen's Compensation Acts in the United States—The Medical Aspect*, pp. 28-29.

135. *Nebraska State Medical Journal*, December, 1928, p. 469.

136. Illustrations of these methods of adjustment are given in *Bulletin 511*, U. S. Bureau of Labor Statistics, p. 86. *Colorado Medicine*, December, 1931, p. 571. *Report South Dakota Industrial Commissioner*, 1928, p. 13. *New York State Journal of Medicine*, May, 1931.

addressed to state medical societies, would seem to indicate that present fees prior to the industrial depression beginning in 1929 were generally as satisfactory to the medical profession as could be expected. A comparison of such official compensation schedules with those adopted by a large number of county and state medical societies as a guide to private practitioners would seem to indicate that the fees in such schedules do not differ widely from those charged to wage earners in private practice.¹³⁷

Some medical societies have opposed the adoption of any fee schedule, especially when, as is the case with those formulated for compensation purposes, they are reduced to offset greater security of payment, because such schedules tend to become standards for all grades of practice.

The Pennsylvania State Medical Society has always opposed the adoption of any fee schedule, largely on the ground that the diversity of conditions in that state is such that any schedule that would be fair in some sections would certainly produce injustices elsewhere. Dr. Francis D. Donoghue, chief medical adviser of the Massachusetts Department of Industrial Accidents, also stated that he had opposed a fee schedule for the reason that it was apt to be based on the "minimum standards of the minimum community" and then applied to state-wide conditions.

A study of the tabulation of these schedules in the appendix and the accompanying charts reveals an almost complete absence of any standards of the value of medical service. While the schedules of some states are clearly lower as a whole than others, even the lowest will have some items above the average of all the schedules, and the highest will pay less for other services. There are few items for which the fee in some states is not at least three or four times what it is in others.

The opinions expressed in the report of the Judicial Council to the House of Delegates of the American Medical Association in 1915, concerning such fee schedules, sets forth these professional criticisms as follows:¹³⁸

137. Comparative table of compensation schedules may be found in the appendix.

138. Proceedings of the House of Delegates, A. M. A., June, 1915, p. 27.

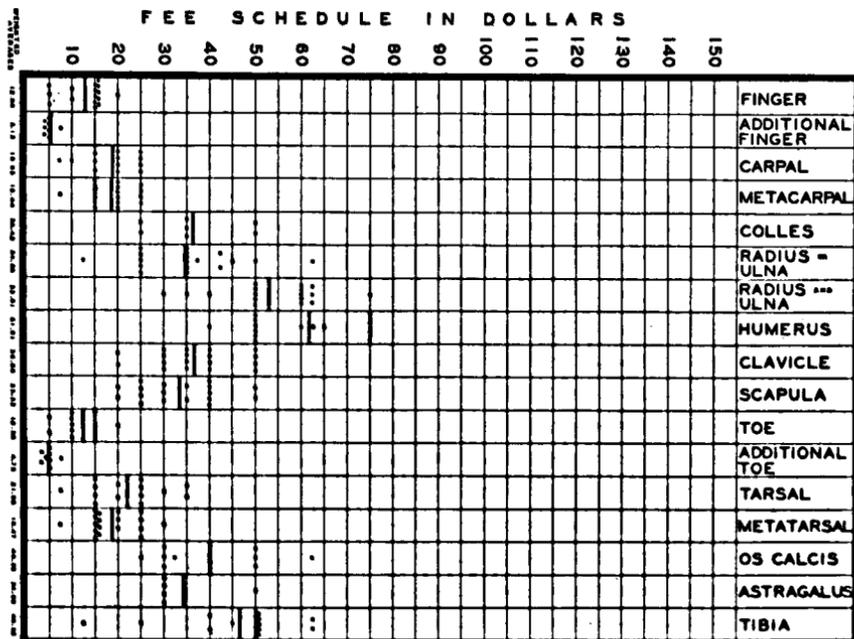


CHART 1.—State Industrial Fee Schedules for Various Types of Fractures Arranged According to Amounts Above and/or Below the Weighted Averages

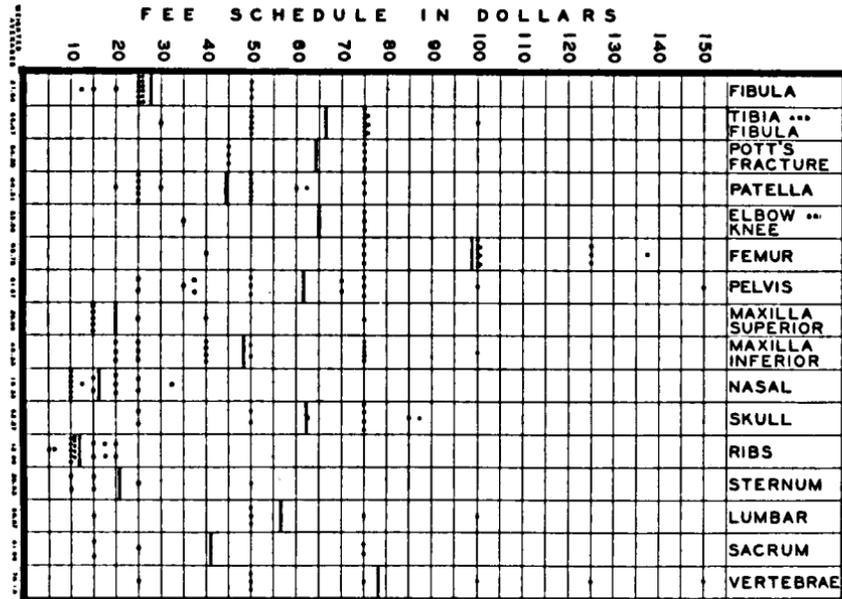


CHART 1.—State Industrial Fee Schedules for Various Types of Fractures Arranged According to Amounts Above and/or Below the Weighted Averages—Continued

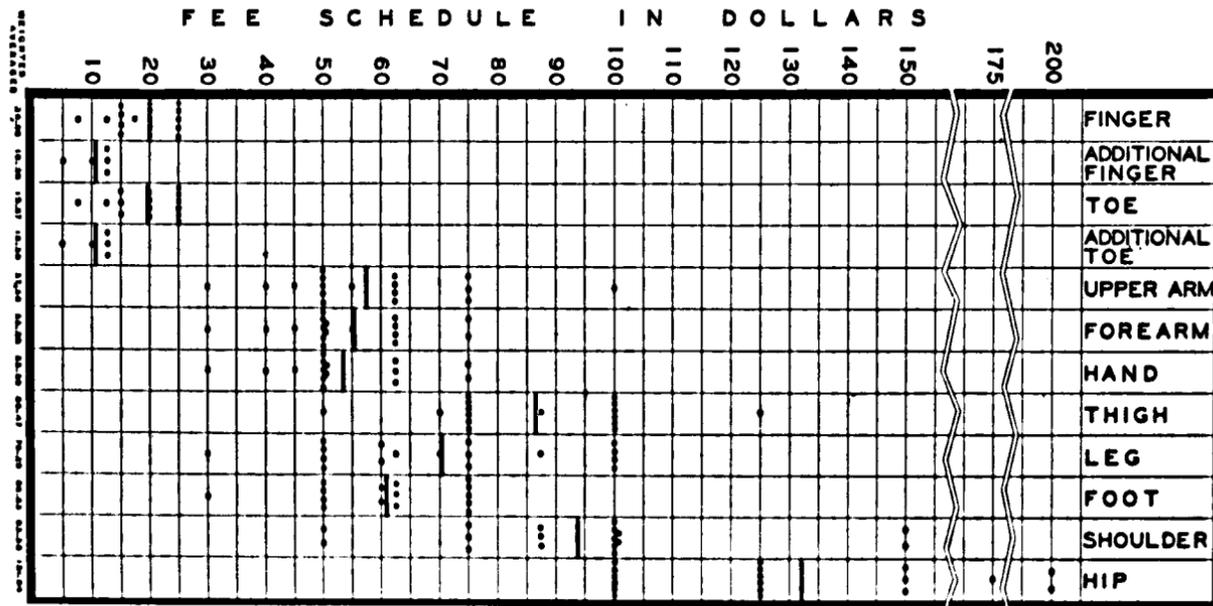


CHART 2.—State Industrial Fee Schedules for Various Types of Dislocations Arranged According to Amounts Above and/or Below the Weighted Averages

"In considering fee bills in general, the opinion is frequently expressed that a fee bill for a special kind of work in any community, such as work under the compensation acts and expressed as a minimum fee bill for such work, soon becomes a maximum fee bill for other members of the community. Patients will demand to be treated for the same schedule of fees whether these patients are under the compensation act or not; and if there be two fee bills, the low one for special work

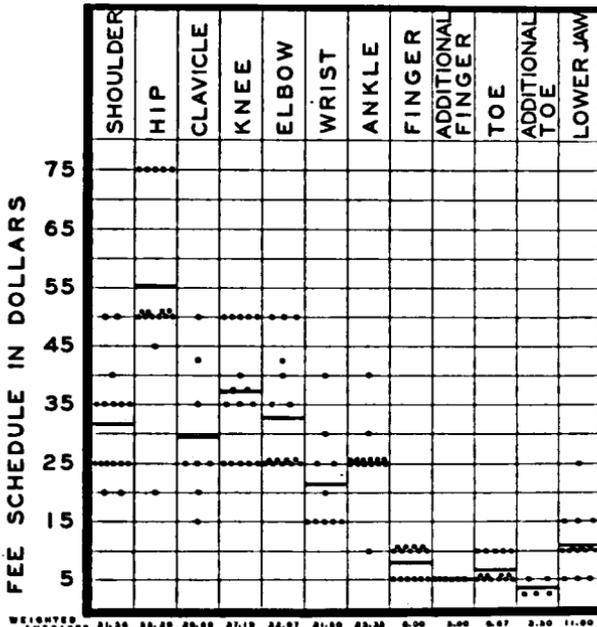


Chart 3.—State Industrial Fee Schedules for various types of Dislocations Arranged According to Amounts Above and/or Below the Weighted Averages.

tends to replace the higher bill in general work. This, of course, can hold only among people with small incomes; but this means the great majority of the people. The flat rate element of any fee bill, as expressed especially in the New York fee bill, works an injustice in many instances. Such a rate is made by the insurance company on the basis of averages for a given injury. This is fair for the insurance company dealing with large numbers of cases, but is not fair to the individual surgeon who deals with few cases, as any single case judged by averages may be overpaid or greatly underpaid for the surgical service rendered. Inflexibility, therefore, in a fee bill tends manifestly to unfairness in the treatment of the individuals

throughout the state. If rates in the fee bill can vary between certain stated amounts, as in the West Virginia fee bill, it will give greater flexibility and render justice to the individual surgeon, or if, as under the industrial commission of Ohio, it is specifically stated that the fee bill is used as a guide and is not a hard and fast agreement between any individual and the insurance companies. . . .

"In considering the formation of any new fee bill, it is worthy of consideration to remember that three quarters of all accidents require less than two weeks' care and that the daily visit to the house and the daily office and dispensary visit will form a large item in the total amounts of surgical compensation. Further, as has already been referred to, in considering the end results of fractures, all fee bills give the major fees to the amputation which, in ordinary cases, requires vastly less skill from a surgical point of view than the fracture. Moreover, as far as the economic results to the patient are concerned, the fracture offers some hope of permanent rehabilitation, whereas the amputation must remain as a partial or total disability. The work on fractures in future will stimulate the medical profession to the employment of their greatest ingenuity and skill in obtaining their best results. It will in the future require a greater exhibition of judgment and skill than any other form of injury to obtain the minimum total or partial disability. Under these circumstances, it should be paid the highest rate of compensation to the medical man. This is contrary to our present fee bills."

It is noteworthy that in whatever localities this long disputed question now appears to be approaching a satisfactory solution, that condition is due to the persistent and painstaking effort of committees of organized medicine who have cooperated in the preparation of such fee schedules.

Any attempt to determine the exact amount paid for medical care in the entire United States is defeated by a scarcity and confusion of statistics even greater than that concerning accidents. The compensation commissions of such great industrial states as New York, Pennsylvania, New Jersey, Illinois, Michigan and Indiana, where the largest expenses are incurred, frankly admit the absence of any accurate statistics of medical care, while a number of others make no pretensions to giving such figures. In only a few states is any attempt made to ascertain the amounts spent for such care by self insurers or under contract, yet in some states this form of care accounts for from 30 to 50 per cent of the medical expenses.

Letters were sent to every state commission and to others who might be able to assist in making estimates when no official figures were available. The National Council on Compensation Insurance furnished statistics of the amounts reported by the various member companies and these figures were used in adjusting the estimates for several states.

With these reservations and explanations, the table on page 98 is offered as the nearest approach to accuracy possible with existing sources of information.

The grand total of these items is, in round numbers, and it is foolish to pretend to greater accuracy—\$67,000,000. This does not include self insurers in most of the states or a large share of contract practice in some states. It was thought better to give the figures furnished by the various state authorities without attempting to include estimates of items excluded unless, as noted, or these estimates were made by some state official.

Wherever the official report definitely states that these items were excluded, this is noted in the table; but additional information has shown that in almost every state a considerable share of the amount actually spent for medical care is omitted. Some study of individual states indicates that the items so omitted amount to at least 15 per cent of the amount reported, and where contract practice is extensive it reached a much higher percentage. If this 15 per cent is added there is a total of \$77,000,000 expended annually for medical care in connection with compensation. There is still another point that should be considered in arriving at any such general estimate: The money expended for compensation varies with the industrial cycle. In nearly every state where figures are available for a series of years, these figures show a sharp peak in 1929, and where the statistics are given for later years in the table they usually represent a decline from that peak.

This annual expenditure of \$77,000,000 is more than is spent for health insurance in any country in the world except Germany. The institutions that have been built up around these expenditures are as extensive as those of any system of social insurance. They gain a far greater importance from the certainty that if any more extensive system of health or unemployment

Amounts Paid for Medical and Compensation by States

State	Year	Medical	Compensation
Alabama ¹	1929	\$ 409,640	\$ 955,828
Arizona	1931	214,823	825,939
California	1930	5,235,471	8,068,436
Colorado	1931	469,617	1,408,000
Connecticut ²	1930	1,741,475	2,284,852
Delaware ³	1929	200,000	350,000
District of Columbia ⁴	1931	4,565,882	9,290,361
Georgia ⁵	1930	369,138	681,630
Idaho ⁶	1930	291,673	768,014
Illinois ⁷	1929	4,320,662	10,801,655
Indiana ⁸	1931	1,207,188	3,621,565
Iowa ⁹	1929	528,408	671,356
Kansas	1931	240,701	829,515
Kentucky	1930	552,957	1,658,872
Louisiana ¹⁰	1929	482,524	1,267,572
Maine	1930	330,784	659,663
Maryland	1930	459,264	542,248
Massachusetts	1931	2,870,552	6,107,505
Michigan	1929	657,724	5,588,213
Minnesota	1929	855,230	2,159,559
Missouri	1930	1,301,751	3,193,980
Montana	1932	105,351	342,218
Nebraska	1927	300,390	692,594
Nevada ¹¹	1930	111,515	413,743
New Hampshire	1930	83,527	254,747
New Jersey	1931	2,637,834	7,951,397
New Mexico ¹²	1931	150,000	400,000
New York ¹³	1931	17,621,851	35,243,703
North Carolina	1930	719,757	1,583,025
North Dakota	1930	196,681	206,592
Ohio	1931	4,733,272	12,230,782
Oklahoma ¹⁴	1928	936,733	1,193,604
Oregon	1931	759,051	1,947,518
Pennsylvania ¹⁵	1931	4,725,449	14,176,349
Rhode Island	1930	314,034	596,546
South Dakota	1930	85,857	181,631
Tennessee ¹⁶	1930	397,032	1,191,097
Texas	1930	1,983,985	4,693,700
Utah	1930	386,672	1,068,870
Vermont	1930	212,706	366,194
Virginia	1930	750,000	1,257,753
Washington ¹⁷	1931	905,438	3,863,868
West Virginia	1930	562,709	4,159,616
Wisconsin	1931	1,101,978	3,486,195
Wyoming ¹⁸	1931	157,658	315,317
		\$67,264,944	\$159,552,024

1. Medical computed at 30 per cent of total.
2. One half of amount given in report for 1929-1930.
3. Estimated; no information available from state officials.
4. Total U. S. employees, longshoremen, and District of Columbia private employees. Includes commission's estimate of \$1,000,000 as value of medical aid added by federal institutions giving free service to employees. Medical for longshoremen and private employers computed as one-third total payments.—Fourteenth Annual Report U. S. Employees Compensation Commission, 1931.
5. One-half 1929-1930 contract excluded.
6. Computed on statement of Industrial Accident Board report that amount given for medical excludes 45 per cent paid under contracts.
7. Medical computed as one-third total.
8. Medical computed as one-third compensation.
9. Medical as reported by National Council on Compensation Insurance. Compensation as given by state commission.
10. Medical as reported by National Council on Compensation Insurance and compensation three times medical.
11. Omits self insurers.

insurance is instituted by any state such systems will tend to follow the patterns already fixed by workmen's compensation.

The question of the trend of the costs of medical care in compensation is of vital interest to all those concerned. It has been shown that in the compensation business handled by stock companies each premium dollar is divided about as follows: the company receives 42 cents, the injured worker receives 38 cents in cash, and 20 cents goes for medical care.

There is much evidence that the stock companies, in order to meet the competition of the mutual and state funds, have frequently and secretly reduced their premium rates, either to preferred risks or to large insurers who also placed other lines of insurance with the same company.¹³⁹ This may to some extent account for the heavy losses the stock companies report as a result of their compensation business, although the main reason for such loss is undoubtedly their excessive cost of acquisition and administration of such business. The constant effort of these companies to shift the blame for these losses from their own expensive management to the physicians and surgeons giving medical care to accident victims makes this whole discussion a vital one in considering the relations of the medical profession to compensation. It makes these questions of the amount and trend of medical costs of special significance.

In this relation also the lack of accurate impartial statistics receives added importance. Inquiry at the U. S. Bureau of Labor Statistics revealed that this supposedly central repository of compensation statistics is completely in the dark concerning total expenditures for medical care. The one general source of such statistics is the National Council on Compensation Insurance, the central rate-making body for nearly all the agencies, except exclusive state funds and self insurers, writing compensation insurance in the United States.

The information on which the council bases its calculations is primarily obtained from reports of the various carriers affiliated with the council and very

139. Final Report of the Joint Legislative Committee on Housing, New York Legislative Document 48, 1923, pp. 79-81. Hobbs, C. W.: Workmen's Compensation Situation, Weekly Underwriter, Sept. 21, 1929, pp. 631-634.

largely from the answers to what is known as "Schedule Z," one question of which calls for all medical expenses incurred, classified as to "compensable" and "noncompensable" cases.

In a letter from the council supplying such information as is available there is an estimate of the "total compensable medical" of \$27,466,332 and of the "total noncompensable medical" of \$13,251,699, giving a total for all medical care of \$40,718,031. Concerning these figures the following explanation is made:

It should be understood that these figures represent experience of National Council members only in the open compensation states. The states of Washington, Oregon, Nevada, Wyoming, North Dakota, Ohio, West Virginia do not permit private carriers to write Workmen's Compensation insurance and therefore the experience of these states is excluded from the above totals. In Pennsylvania and Delaware the Workmen's Compensation insurance is entirely under the control of a state operated bureau and we do not have the figures for these states. Arkansas, Mississippi and Florida do not have compensation laws. The experience for the remainder of the states is included with the exception of Massachusetts, where we do not have a split between compensable and noncompensable medical. However, there are a number of companies writing Workmen's Compensation which do not belong to the National Council and we have therefore not been able to include figures for these companies, but we believe the figures that we have given you include the majority of the experience for the states represented as the non-Council member writings are relatively unimportant.

With the addition of these omitted states and estimated allowances for other omitted items, the total is not far from the estimate already given and is therefore a check on the accuracy of this previous estimate.

The question of the trend of medical costs and its causes has an even sharper bearing on certain very important issues than the total of such costs at any given time. Spokesmen for the stock companies have claimed that increasing medical costs are due largely to excessive charges by physicians and that such costs in recent years are absorbing a constantly increasing share of the portion of the premium dollar available for the relief of injured employees. If this were true there might be many things that would justify it aside from excessive charges by physicians. It has been seen how growing recognition of the value of the best medical

care has been reflected in increasing "liberalization" of medical provisions in nearly every state, a movement that must increase the cost of such care. Moreover, there are few subjects receiving greater attention in the field of medical treatment today than that of the "increasing cost of medical care" due to scientific progress. The question, therefore, of whether any upward trend in compensation medical costs is fully accounted for by the foregoing causes or whether it is due to excessive payments to physicians becomes of considerable importance.

The Council on Compensation Insurance compiled a series of figures from affiliated states showing this trend. There are three sets of these figures—premiums, cost per case, and loss rates—all showing practically the same trend. As the first and third of these are somewhat difficult to understand by any one not familiar with insurance terminology, only the second one is given in the accompanying table.

The significance of these figures was explained, as follows, in the accompanying letter:

The figures in the column headed Cost per Case are, as Mr. Skelding explained to you, the total medical cost divided by the number of compensable cases. The Workmen's Compensation laws of the various states provide that compensation will not begin until after a certain definite period known as the waiting period. If the disability does not extend beyond this waiting period the employee is not entitled to compensation and none of the details of the case are reported to the National Council. Any medical incurred on such a case is included with medical incurred on other cases of a similar nature and the total only is reported to the National Council. We therefore do not know how many of these noncompensable cases there are, but it is a reasonable assumption that the number of such cases would vary directly as the number of compensable cases and therefore our index of Cost per Case is perfectly valid to indicate the trend.

As soon as these figures were received, an effort was made to fill out the same facts from the reports of compensation commissions in states not included in the council figures. It soon became evident that there was considerable divergence between the figures from these states and those received from the council. Moreover, when the official reports from the states in the council table were similarly compared, the result obtained by dividing the total expenditures for medical

care by the total number of compensable accidents as given in the official reports was usually much less than the amounts shown in the council tables.

When the facts were reported to the Council, the following explanation was received:

We might state at the outset that we are not surprised at the discrepancy between our figures regarding the cost per case

Cost of Medical Care Per Case

State	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929
Ala....	\$...	\$ 46	\$ 45	\$ 50	\$ 55	\$ 59	\$ 71	\$ 73	\$ 81	\$ 81
Calif....	106	106	107	107	104	119	127	133	136	141
Colo....	87	83	84	83	74	96	96	104	119	113
Conn....	91	91	93	98	110	116	119	120	124	131
Ga.....	..	36	43	47	51	55	55	53	58	62
Idaho...	63	90	70	64	62	66	64	96	81	95
Illinois.	81	80	83	88	93	97	101	98	103	108
Indiana.	49	46	50	51	56	61	66	67	70	74
Iowa....	83	85	96	100	110	121	127	126	131	149
Kansas.	59	57	63	69	67	76	76	80	81	91
Ky.....	41	42	46	46	51	56	57	62	64	70
La.....	36	34	33	36	39	44	46	48	50	55
Maine...	49	52	57	60	66	64	69	74	70	79
Md.....	46	48	44	49	48	48	55	60	60	61
Mass....	62	64	68	73	79	82	84	83	81	86
Mich....	79	73	75	79	84	87	92	95	93	101
Minn....	73	67	68	73	73	75	81	82	88	93
Montana	116	132	159	147	139	136	144	162	141	149
Neb....	67	72	78	83	86	93	101	97	109	105
N. J....	69	66	71	75	78	84	89	95	98	107
N. M....	69	73	75	54	89	105	91	97	76	87
N. Y....	76	79	80	87	93	100	103	108	116	124
Okla....	74	64	68	68	76	78	86	90	90	95
R. I....	65	74	76	77	81	89	90	89	88	94
S. D....	34	31	30	30	33	37	34	31	34	40
Tenn....	54	53	53	53	52	57	58	59	63	64
Texas...	71	55	53	63	64	62	81	73	85	89
Utah....	50	49	51	55	51	56	63	59	63	63
Vermont	39	44	51	53	56	54	64	63	65	69
Virginia	60	55	59	61	65	68	76	78	73	81
Wis....	50	51	52	54	56	61	63	71	72	73
National	77	75	78	82	79	85	90	94	96	102

and those which you have obtained from the official publications of the different state bodies. As stated in our previous letter, the figures for cost per case which we have used do not represent the actual average cost obtained by dividing the total amount of medical paid by the total number of cases in which medical was paid. Our figure was simply a comparison of the total cost paid shown against the number of compensable cases; and while it is of no value in determining the actual average amounts paid for medical cost, it is perfectly reliable in determining the trend of medical cost from one year to another and should be regarded as an index number rather than as an actual value.

Another method of testing this trend is possible in a number of states, where the total amounts paid for compensation and medical care for a number of years are available. The percentage of medical care to the total expenditures for compensation and medical was calculated for such states as give this information and is shown on the accompanying graphs.

These include states with exclusive and competitive funds as well as those with no such funds and are sufficiently numerous and well distributed geographically to constitute a fair sample. An examination of these graphs will show that in spite of some exceptions there is no pronounced upward trend during the last half dozen years and therefore little indication that the share of the premium dollar that is expended on medical care is increasing at any such alarming rate as many recent writings claim.¹⁴⁰

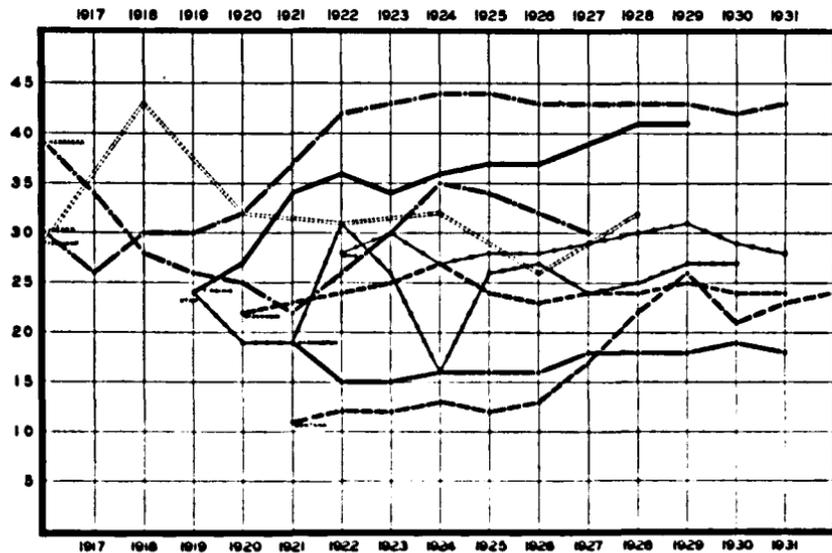
This graph gains added significance in view of the continuous and extensive "liberalization" of the provisions for medical care which has been described. This "liberalization" was brought about in part by a recognition that the value of such care to the accident victim is greater than any cash indemnity and in the second place by the recognition of the employers and carriers that adequate medical care reduced cash compensation. A corresponding liberalization was taking place in regard to the originally equally inadequate cash payments. The maximum wages on which compensation may be calculated has been raised, the waiting period shortened, the maximum payable in every form of injury increased, the length of time during which permanent disability is paid extended, occupational diseases made compensable and in every way the amounts payable to the injured worker increased in practically every state.¹⁴¹

It is difficult to draw any reliable comparison as to the relative rate of increase in the two fields of cash and medical compensation, but where a change is seen in medical care from a limit of \$50 or \$100 and thirty days to unlimited either as to time or amount, it is clear that the rate of increase is greater than any that have been made on the cash side. On the other hand, an

140. See statement of George S. Van Schaick, New York State Superintendent of Insurance, in U. S. Daily, Sept. 30, 1932, where existence of this trend is questioned.

141. Insurance Facts for Policyholders, Bulletin 37, Insurance Department, Chamber of Commerce of the United States.

PERCENTAGE OF TOTAL COMPENSATION COSTS PAID FOR MEDICAL CARE
IN CERTAIN STATES ARRANGED BY YEARS



accident victim sometimes requires medical, and even hospital, care for life at an expense of thousands of dollars. The x-rays were rarely used in the first years of compensation. Most carriers and commissions now demand several films for their records in each case of fracture. In some jurisdictions the use of antitetanus serum in every case of an open wound is required by the commissions, usually at the insistence of the carriers. In a dozen other similar ways, more expensive methods of modern medical science are rightfully demanded in the care of the injured worker.

The insurance carriers are demanding all this increased care, but they are using all the tremendous political and financial power that they possess to pass these additional costs on to the physicians and the hospitals. They do not even suggest that the amount of medical care should be reduced by law. They are well aware of the popular uprising that would greet any such proposal. A vast mass of evidence exists, some of which has been cited, to show that the carriers often lower the quality of the care below the legal limit by indirect methods, such as contracting with unscrupulous or economically hard pressed physicians to give an impossible amount of medical care for insufficient pay, by establishing clinics and hospitals understaffed with incompetent employees, and by seeking continuously to exploit public and private charity.

This point has been discussed at some length because this alleged excessive increase is just at present being made the excuse for a demand by the stock companies that premiums be increased from 10 to 25 per cent, a demand that is opposed by the mutuals, who hold that present premiums are ample for an economically managed carrier,¹⁴² and also for a demand that medical fee schedules be reduced. The latter move is at present well under way, the Nebraska commission having already announced a prospective 20 per cent reduction, and Kansas proposed a new schedule on a lower level

142. *Industrial Review*, published by Illinois Manufacturers' Association, August, 1932, p. 7. Best's Special Bulletin Service, Dec. 28, 1932, states that New York State has granted an average increase in compensation insurance rates to the stock companies of 3.6 per cent instead of the 9.2 per cent requested. Missouri granted an increase of 16.8 per cent for 1933 instead of 31 per cent requested. Michigan increased rates 15 per cent where 16.9 per cent had been requested, and Alabama refused a request of the stock companies for an increase of 9.2 per cent and also of the nonstock companies for a decrease of 0.8 per cent in rates.

of prices. The Oregon State Industrial Accident Commission made a first reduction of 35 per cent of the existing fee schedule and then in 1932 a further 25 per cent reduction and is therefore now paying but 58.70 per cent of the original schedule. The letter of the chairman of the commission to the president of the state medical society proposing the second reduction has this significant closing paragraph:

"You are aware of course that doctors are now, and have been for a considerable time in the past, doing the same character of work for Hospital Associations, that they do for us, and at a lesser rate, which seems most unfair."

This, of course, simply means that the undesirable conditions created by contract practice are to be used to beat independent physicians down to the level of contract prices and service. These are exactly the tactics that have been pursued in every country where the control of medical service has passed into the hands of commercial organizations. This always means that commercial competition for cheapness is substituted for professional emulation in service. The two are mutually exclusive. Commercial competition will not tolerate free choice of physicians, which permits a comparison of service and encourages continuous progress. It seeks to level all services down to the point at which they can not only be fitted conveniently into a cost accounting system, but also where they will yield a profit to the management without seriously affecting sales to the consumers; i. e., the employers who pay the premiums. The result is destruction, distortion and deterioration of the most valuable features of medical service.

CHAPTER VII

PROFESSIONAL RELATIONS IN COMPENSATION

Two aspects of the relations of physicians to the system of compensation have been especially considered — the choice of physician and payment for service. Any system of medical care that vests the responsibility for payment elsewhere than in the individual treated calls for records and reports from the physician to the source of the payment. When action in regard to other financial transactions is based on the judgment of the physician, these reports grow longer and more numerous. Now it seems to be a common characteristic of the majority of physicians to dislike "paper work" and they are seldom trained to do it. This attitude may have been, to some degree at least, a contributory factor in causing compensation practice to drift into the hands of the more business minded members of the profession.

Most of the compensation systems require an immediate report of the accident by the attending physician or surgeon. Some provide that this must be signed by the injured worker and others that it must be transmitted through the employer. Some limit these reports to serious cases, others require a report only if the disability continues for a definite period.¹⁴³ In spite of efforts at standardization, these reports vary widely as to the extent and character of the information required. Nearly all ask the name, address, place of employment, nature of work performed and other information concerning the patient which a busy practitioner seldom inquires about, especially in any emergency case such as an accident. The physician is also asked to describe the injury in detail and usually to make a prognosis of the probable extent of disability. If these reports are not returned within a specified time, the bill for medical care will not be paid under some systems.¹⁴⁴

143. Hookstadt, Carl: Comparison of Workmen's Compensation Insurance, Bulletin 301, U. S. Bureau of Labor Statistics, 1922, p. 39. Harris, M. L.: The Physician's Burden Under Workmen's Compensation, J. A. M. A., March 6, 1929, pp. 644-645.

144. Journal of the Michigan State Medical Society, March, 1931, pp. 195-196. Journal of Medical Association of Georgia, September, 1928, p. 412. Texas State Journal of Medicine, June, 1930, p. 108.

There can be no question of the necessity of reports if the machinery of the compensation system, which rests so largely on medical opinions, is to work. The tendency of the private practitioner to be neglectful of such reports is another reason why employers, insurance carriers and administrators of the law try to confine compensation practice to those physicians who specialize in such work and are consequently prompt and thorough in fulfilling these regulations. Medical journals and societies are constantly seeking to impress on physicians doing compensation practice the necessity of making out these reports in proper form.

The insurance carriers have taken advantage of this spirit of cooperation to enlarge their demands for reports far beyond the legally established limits. This practice led to such abuses that general protest was made by the physicians and the following resolution was adopted by the House of Delegates of the American Medical Association, May 27, 1927:

"WHEREAS, There is a growing tendency on the part of some insurance and indemnity companies, as well as industrial concerns, to impose on physicians by requesting or expecting that more or less complete physical examinations, including written reports of same, or that a written expert medical opinion concerning patients shall be made for nominal fees or perhaps no fees at all, and that there is increasing tendency on the part of such organizations or concerns to shift responsibility by making erroneous claims that the services are in the interests of the patient or client from whom the physician cannot justly claim compensation; therefore be it

Resolved, That it is the sense of the American Medical Association as represented by this House, that the members of the American Medical Association are under no moral or legal obligations to furnish professional services or expert professional opinion concerning any patient, or reports concerning professional services rendered any patient, to insurance or indemnity companies, to industrial concerns or their agents, or for the benefit of any third party, unless paid the customary fees charged by the medical men of that community for similar services rendered to private patients."

Making out reports and testifying in compensation cases raises the question of professional secrecy. For centuries the confidences given to a physician by his patient, like those to a lawyer by his client or by a confessor to his priest, have always been held inviolate. But some of the compensation laws directly state that

the physician attending an injured worker must testify as to all facts bearing on the compensation award, that may be learned in the course of the treatment, and most of the laws provide that the ordinary rules of evidence do not apply in hearings before commissions. The decisions of the courts are somewhat vague and conflicting as to the limits of such confidential information that must be revealed.¹⁴⁵ The sharpest conflict comes over the question whether a physician may be required to testify concerning knowledge of previous illnesses, which he may have gained in treatment prior to the accident. Another point that has caused considerable friction is the extent to which a physician in compensation can be required to give opinions, thus qualifying as an expert witness, without receiving fees as an expert.

The question of professional secrecy became particularly sharp in Ohio, where "Several years ago a Columbus physician was murdered in his office by a patient because of a medical report which the physician had filed with the Industrial Commission in connection with the man's application for workmen's compensation."¹⁴⁶ Ohio is also an example of a state where the state medical society has always maintained a policy of close and cooperative relations with the compensation administrators. Because this policy has proved to be of greatest importance in securing and maintaining a satisfactory adjustment of many of the questions that create friction, it deserves particular attention. A letter of Don K. Martin, secretary of the Ohio Medical Society, explains the growth and application of this policy:

"While the medical profession through medical organization was much interested in the enactment of the original workmen's compensation law in this state, the medical 'viewpoint' at that time had comparatively little weight with the legislature in as far as the provisions of the workmen's compensation law were concerned. Since that time, however, the medical profession through the State Medical Association, and especially through the Committees on Public Policy and Medical Economics, has been in constant close touch with all developments and with all amendments to the workmen's compensation law as well as

145. National Industrial Conference Board: *Workmen's Compensation Acts in the United States—The Medical Aspect*, 1923, pp. 77-78. Allen, Mathew H.: *What Power Should Commissions and Boards Have to Compel Testimony?* Bulletin 536, U. S. Bureau of Labor Statistics, pp. 60-74.

146. *Ohio State Medical Journal*, May, 1931. Full discussion, *ibid.*, May, 1932, pp. 357-359.

with policies and procedure in its administration. As an illustration it may be stated that frequent conferences are held with officials of the Industrial Commission and there has developed a mutual spirit of cooperation. This office and appropriate committees are frequently consulted by officials of the Industrial Commission in regard to new regulations and administrative procedure."

As a result of such conferences, "steps have been taken by the commission to safeguard physicians in the submission of medical information to the commission."¹⁴⁷

"There has been printed on the new workmen's compensation application forms, which are signed by the claimant and filled out for the most part by the attending physician, a statement authorizing the physician to make disclosures of diagnosis and treatment of the claimant who signs the application to the State Industrial Commission and others authorized to receive such information without incurring civil liability to the claimant."

The attitude of the physicians of Ohio in regard to the compensation situation is best shown by the statement in the report of the Medical Economics Committee that "in many ways the Ohio compensation law is superior to the compensation laws of other states and that in general it is more satisfactory to all groups and individuals affected by it."¹⁴⁸

While the result in this case has been of value to the physicians of Ohio, the policy that secured this result is of far greater importance. It has already been pointed out that the extent of friction of medical relations in compensation matters seems to bear little relation to the forms of compensation institutions. Comparatively smooth working or constant friction may be found where either state funds, stock companies or mutual associations exist. These relations seem little affected by the presence or absence of fee schedules or of many other things over which there is sharp conflict in some states, if there is a definite continuous contact between organized medicine and the compensation authorities.

There is an indefiniteness about this phase of the subject that makes it difficult to set down hard and fast descriptions of the policy that has brought about these results. It is really another example of the fact that, in social relations, human, personal and more or less

147. Ohio State Medical Journal, May 1, 1932, p. 357.

148. Ohio State Medical Journal, Oct. 1, 1930, p. 943.

individual contacts are often of more importance than laws and institutions. In a paper read before the Medical Association of Georgia, C. W. Roberts¹⁴⁹ said:

"Convinced from the outset that the provisions of the act, in common with those generally in operation, anticipated the free use of sound medical opinion in its administration, the Georgia Commission has constantly availed itself of the services of our profession in rendering of awards concerned with medico-legal questions. Whatever criticism, if any, that might be justly lodged against the lay administrators of these acts, concerned so much with medical problems, in other states, cannot with equity be maintained in Georgia."

In Maine there is mention of "a frank discussion of the differences arising between the companies and attending physicians."¹⁵⁰

At a little later date the president of the state medical society in his presidential address said concerning the industrial accident law:¹⁵¹ "It is universally appreciated by the patient, generally approved by the physician, accepted by the manufacturers, and wholly disregarded by the consumer, who pays the bills."

In New Jersey, although the law did not make such an appointment compulsory, a physician, Andrew F. McBride, was for many years labor and compensation commissioner. He¹⁵² describes his policy as follows:

"Having been a practicing physician myself, of many years' standing, before taking up the duties of Labor and Compensation Commissioner, I was desirous of seeing that all proper medical bills were paid, and that right promptly. To bring this about I set up arbitrarily in many parts of the state, Medical Boards consisting of 3 members; 1 member was selected by the Medical Society, 1 by the carriers and 1 by the state, so that all disputed bills could be referred to these Boards for the purpose of being reviewed and passed on. . . .

"There were several such Boards in the state, all serving loyally and devotedly. My thought is that they should be continued by law and that the man selected by the county society in each district be paid for his services."

Not but that there has been some dissatisfaction in New Jersey.¹⁵³ There has been the same tendency to

149. Roberts, C. W.: *Journal of the Medical Association of Georgia*, July, 1929, p. 319.

150. *Maine Medical Journal*, May, 1927, p. 101.

151. *Maine Medical Journal*, July, 1930, p. 120.

152. McBride, Andrew F.: *The Compensation Act in Relation to Doctors and the Practice of Medicine*, *Journal of the Medical Society of New Jersey*, July, 1930, p. 574.

153. Sommer, George N. J.: *Presidential Address*, *Journal of the Medical Society of New Jersey*, July, 1931, p. 540. *Ethics and Industrial Medicine*, *ibid.*, March, 1930, p. 253.

"commercialize this branch of surgery" that has been found elsewhere.¹⁵⁴ Yet in spite of these evils one finds the secretary of the state medical society boasting of the superior relations of the physicians in compensation work in New Jersey as compared with those in neighboring states.¹⁵⁵

The provisions of the Utah law are much like those of some other states where there is the most bitter complaint and denunciation of their workings by the medical profession. Yet there is very little complaint by organized medicine in Utah. Perhaps the explanation is found in the following extract from the report of the Committee on Industrial Medicine:¹⁵⁶

"Our Committee on Industrial Medicine met with the Industrial Commission of Utah every week and adjusted claims, and saw patients and doctors. A great variety of cases were discussed. The Industrial Medicine work in Utah has assumed a large aspect and a great many cases are being taken care of by regular physicians, and a great many by corporations (through their doctors). The work at times has been quite heavy, but I think it has been handled quite satisfactory."

A corresponding quotation from the industrial commission further explains this policy and its results.¹⁵⁷

"In addition to the formal Hearings held before the Commission, a committee of three physicians, appointed by the State Medical Society to serve for a period of three months each, meets with the Commission on one morning each week, for the purpose of adjudicating medical bills on which there may be a dispute between the doctor and the insurance carrier. It is also the practice to bring before this Commission injured employees, in order that the doctors may examine and determine whether in their opinion the employee's physical condition is fixed, or whether further medical treatment is indicated; and if in their opinion, the condition is found to be fixed, the approximate extent of permanent loss of function, if any, then existing; and any other question which may have arisen regarding the condition of the applicant. This service is entirely free and an average of seven injured employees are examined at each session of the Committee. The assistance accorded the Commission, injured employees, insurance carriers and employers by

154. Martin, J. W.: *Relation of Traumatic Surgery to Industry*, Journal of the Medical Society of New Jersey, January, 1931, p. 6.

155. *Journal of the Medical Society of New Jersey*, December, 1929, p. 881.

156. *Transactions of the House of Delegates, California and Western Medicine*, November, 1925, p. 1470. Brown, John Z.: *The Industrial Commission of Utah and Its Relation to the Medical Profession*, Colorado Medicine, January, 1933, pp. 33-36.

157. *Bulletin 1, Industrial Commission of Utah*, 1928, p. 7.

this Committee has been of inestimable value and much praise should be extended to the State Medical Society for the loyalty and the attention given to this phase of the work."

There are frequent references in reports of the various commissions as to the value of medical cooperation. Although California is not one of the states in which the medical relations have been adjusted to the satisfaction of the profession, yet the department of industrial relations, in its first biennial report, 1927-1930, pays the following tribute to professional cooperation and also comments on some other matters that bear on questions previously discussed:

"This matter of cooperation by the members of the medical profession has been, and is, the subject of much gratification by the Industrial Accident Commission. The service required of the special medical examiners is often irksome, it is exacting, and the remuneration is not comparable to that which our average special medical examiner must receive from his average case. Part of the work, therefore, is done for the good of the cause and with the desire to contribute to, and cooperate in, a humanitarian movement.

"This office has, with very few exceptions, never been denied the services of any of the leading physicians of the State of California for special examiner work.

"Members of the faculties at the medical colleges and the most prominent practitioners everywhere are on our list, and contribute their services when called upon. The value of this service can be better understood when it is realized that the Industrial Accident Commission is often confronted with vastly divergent opinions. The class of men comprising the list of special medical examiners makes their opinions authoritative.

"In sad contrast with the services of these specialists are the services of some physicians whose results come before the Industrial Accident Commission for scrutiny and decision. The Industrial Accident Commission has always held that the best surgical service that is to be had is not perfect—it is none too good. The Industrial Accident Commission has always held that the services of the men best equipped by knowledge and experience would be most economical in the long run.

"Many of the insurance companies are inclined to practice economy in the selection of physicians and surgeons who are willing to take less for their services than a legitimate fee, and to ignore the false economy following poor results. Some insurance companies and medical service organizations have actually gone so far as to contract to furnish medical service. In such an arrangement, the patient-doctor equation is lost, with detriment to the service. Furthermore, such arrangements may be illegal for the reason that the right to practice medicine is

vested by law in the man who secured the license to practice medicine, and not in an organization which dispenses wholesale medical service."

It may be worth noting that such cooperation as is conducted in Utah and California and in a number of other states involves a considerable contribution of free or underpaid services on the part of the medical profession. Moreover, there are some states in which the administrators of the compensation law have shown an inclination to reject all cooperation. The report of the Committee on State and Industrial Affairs of the Oregon Medical Society says:¹⁵⁸

"For three years our Society had tried in every honorable way to cooperate with the State Industrial Accident Commission, and to offer our services, so far without definite results. . . . In spite of our efforts the Commission persists in refusing the help which is offered free of cost and that could surely be of great advantage."

There have been ample illustrations of the discontent of physicians with the workings of compensation systems. It is something of a relief to cite these illustrations of more satisfactory relations. It would be possible to cite some others, and perhaps reference should be made to the situation in New York, where, almost from the enactment of what is claimed to be the first compensation law in the United States, there has been a turmoil of complaints, accusations and investigations rivaled in virulence only by the corresponding situation on the other side of the continent in the state of Washington, whose compensation institutions differ as widely as any to be found from those in New York. Yet in the latter state the careful, painstaking and statesmanlike work through a series of years of the committee of the state medical society seems about to produce a comparatively harmonious and satisfactory solution.

The Committee on Medical Economics of the Medical Society of the State of New York, after several years of study and discussion, laid down a policy which was endorsed by the house of delegates of the state society.¹⁵⁹ Many of these recommendations have already been translated into action either through an understanding with the insurance carriers or by action

¹⁵⁸ Northwest Medicine, January, 1932, p. 36.

¹⁵⁹ Annual Report of the Medical Society of New York, 1931-1932, pp. 25-26.

on the part of the compensation authorities. Some of them still remain subjects of dispute; but the influence of organized medicine is now perhaps the most influential force in determining the future development of compensation conditions. A very significant phase of the new situation is the outcome of arrangements that have been made with the insurance carriers. Practically all the stock and mutual companies, as well as the state fund and self insurers, have joined in agreeing to cooperate according to the terms of what has been designated as a "gentleman's understanding." Some of the more significant points in this understanding are those dealing with the choice of physician, the arbitration of disputes and the question of proper medical reports. Previous to this understanding, only physicians "authorized" by the carriers could treat compensation cases with certainty of receiving payment. According to the new agreement:

"The carriers agree to waive the question of authorization for family physicians who are members of the County Medical Society and who will comply fully with the agreed plan of the County Medical Society and the carriers. Reasonable charges for services of such physicians will be promptly paid."

In return for this general authorization of all society members:

"The members of the County Medical Society agree to seek the advice and abide by the decision of the carriers as respects consultations, x-rays, physical therapy and other treatment beyond ordinary treatment, and, further, the physicians will cooperate with representatives of the carriers in securing for the carriers examinations of claimants at reasonable times."

Machinery has been set up in the form of a joint arbitration board for the settlement of all disputed bills for services, thus doing away with one of the most annoying causes of friction. In connection with the understanding, a tentative fee schedule has been adopted which governs the charges in compensation work. Each county is free to accept or reject this arrangement. A number of counties, including some of the most important industrial centers, have already adopted the plan and those immediately concerned with it expressed great satisfaction with its operation up to the present time.

Without for an instant belittling the defects in and the need of change of compensation laws and institu-

tions, some of which seem almost designed to work an injustice to the medical profession, of such paramount importance in the operation of the law, these illustrations would seem to indicate that it is possible greatly to improve medical relations even under the most undesirable institutions. The factor that is peculiar to the states mentioned is the existence of a hard working committee of the state medical society, supplemented in some instances by local committees the members of which have thoroughly studied all elements of the situation. This committee has then met regularly and fairly frequently with the compensation officials. At these meetings, specific problems are continually threshed out and in the process of the discussions general principles evolve and necessary changes are made so evident that there is little resistance to them.¹⁶⁰

To be sure, this assumes a spirit of cooperation on both sides and some compensation bodies, like that of Oregon, may refuse such cooperation. There will also inevitably be questions that cannot be settled by compromise and over which a legislative, legal or political conflict will be necessary. But the medical society that has behind it several years of such study and consultation will go into such a conflict infinitely better equipped and with greater prospects of success than one that is rushed unprepared into a struggle perhaps for its most highly valued principles and ideals.

A large number of the compensation administrative bodies have medical departments, and practically all have the right to appoint physicians to make examinations of claimants, the report of whose findings is the basis of compensation adjustments. The usual fee paid such "impartial examining physicians" is \$5 and traveling expenses.¹⁶¹

When a chief medical examiner, adviser or director is attached to the commission he is usually a salaried employee, sometimes with quite an extensive staff. Some of these are employed on a part-time basis. Only in the state of Washington is any such medical official

160. See annual reports of the Committee on Medical Economics, published in the Ohio State Medical Journal, in May of each year, for full information on the relations of the Ohio State Medical Association to the compensation situation.

161. National Industrial Conference Board: *Workmen's Compensation Acts in the United States—The Medical Aspect*, 1923, p. 23.

a member of the commission with any voice in the decision of medical questions.

The special report on "Uniform Medical Provisions for Workmen's Compensation Acts in the United States, issued by The National Industrial Conference Board (1925), has as one of its recommendations (page 16) that "There should be attached to each compensation commission a physician who should be the medical director. He should be appointed from a group of at least three physicians proposed by the State Medical Society as being qualified for the position."

The New York Industrial Survey Commission recommended that a medical advisory committee be created by law "to consider all matters connected with the practice of medicine submitted to it by the Industrial Commission, the Board or the Industrial Council and to advise them in respect thereto."¹⁶²

These efforts have had little effect. The physicians connected with compensation commissions continue, with few exceptions, to be underpaid and overworked and to be given little real authority. When the National Industrial Conference Board investigated this medical aspect of workmen's compensation in 1923 it found only fifteen states having anything that might be designated as a medical department of the administrative body of workmen's compensation.¹⁶³

A questionnaire and examination of laws and reports shows two more in 1932, Arizona and Georgia, now reporting such a department, while Kentucky has dropped its medical department and Pennsylvania established one that had been authorized several years before.

Except in two states, New York and Washington, the payment of such physicians averages about \$2,000 a year, with many on a part-time fee basis.¹⁶⁴

From all the information available it seems safe to estimate that the amount paid to physicians regularly

162. New York Legislative Document 87, 1928, pp. 60-63. See also Virginia Medical Monthly, November, 1925, p. 522. Nebraska State Medical Journal, September, 1929, p. 374, and Bulletin 564, U. S. Bureau of Labor Statistics, p. 22, for recommendations of conference of Eastern states on compensation legislation.

163. National Industrial Conference Board: Workmen's Compensation Acts in the United States—The Medical Aspect, 1923, pp. 23-25. Conditions have changed very little since this was written.

164. See Seventh Biennial Report Workmen's Compensation Service of Iowa, 1926, p. 12, where a plea is made for an increase in the salary of the medical adviser from \$1,200 to \$2,000 a year and where his duties are described.

connected with compensation administration is less than \$50,000 annually in the whole United States. This does not, of course, include fees to "impartial physicians" who are called in to decide specific cases and who generally receive from \$5 to \$10 for this service. It does include all those whose position might enable them to influence the workings of the system. In most states their influence is admittedly very slight. Their duties are generally described as deciding disputed questions of disability or passing on the bills of physicians in compensation cases.¹⁶⁵

In no state is organized medicine given any voice in the selection of these officials. Their qualifications are determined by lay judgment, not always unaffected by political and other considerations. In a few states where, as has just been described, there is close cooperation between a state medical society and compensation officials, the influence of organized medicine in determining policies and appointments is often very great but it rests on no legal basis and may disappear with any political change.

It is somewhat difficult to assign the responsibility for the completely successful, although usually silent, opposition to every effort to secure medical representation or adequate pay for the physicians employed in compensation administration. The employers and insurance carriers can probably be assumed to belong to this opposition, as a part of their effort to keep down payments to physicians. Members of commissions naturally react against any move that would reduce their authority. So it remains true that the physicians, who are the only persons concerned with compensation who have undergone a long course of training to prepare them for their work, and whose decisions are so vital to every action, still remain the lowest paid and with almost the least influence in compensation administration of any parties concerned.

165. Stanley, H. M.: Should the Compensation Board Have in Its Employ a Staff Physician or Physicians? Bulletin 511, U. S. Bureau of Labor Statistics, April, 1930, pp. 310-323, with subsequent discussion and reports from several states.

CHAPTER VIII

COMPENSATION AS ORIGIN AND FOSTERER OF CONTRACT PRACTICE

Social institutions are seldom consciously created. They grow out of previous situations and conditions and usually have developed considerable strength and established significant interests before their importance is recognized by those concerned with the older institutions which the new are supplanting. One reason for this is the tendency of any change to establish new nuclei of what might well be called social crystallization. When workmen's compensation was introduced into the social fluid it created a multitude of these nuclei. It brought together a great number of groups for common legal and financial treatment in regard to accidents. This treatment carried these groups along quite a complex social process of investigation, treatment, adjustment and payment of compensation. As each of these phases was standardized, pressure was automatically brought on the other phases to force them to keep step and become standardized.

Such a process is as unconscious in its operation as the assembly line of a factory that imposes standardization without regard to the effect on the persons and processes affected. Yet even industry is a human process and sometimes learns, at great cost, that not everything is suited to assembly line systems.

When compensation laws were enacted there were a few industries, usually in isolated regions, employing "company doctors." Labor was protesting against the character of the medical service furnished. The physicians employed were seldom of high grade. They were poorly paid and overworked. Compensation brought a number of new forces to bear on plant medical systems. Heretofore these systems had been looked on almost as necessary nuisances, without which an isolated labor force could not be maintained. The money spent on them was begrudged as a penalty laid on those industries because of their location.

When the employer was punished for the injuries of his workmen not simply by the loss of their labor but

by a direct financial penalty, the plant medical system became capable of more than "earning its way." It could cut down compensation payments and reduce insurance premiums in ways already discussed. When the compensation laws permitted and, in some cases, encouraged "self insurance" and the safety and personnel movement discovered other very good values in plant medical care, the result was an excessive acceleration in the growth of such systems. They left the isolation of mining, lumber and railroad camps and entered the great cities. They were no longer established to meet a complete absence of medical facilities but rather for more effective, standardized mass competition with well established adequate facilities.¹⁶⁶

So steadily and almost stealthily has this development proceeded that today more than a million workers receive their medical care from such plant systems, and the rate of growth increases yearly. These plants are extending the scope of their service as rapidly as their numbers. The first "company doctors" were in communities composed almost exclusively of the employees—usually single men. Their practice was largely concerned with accidents, which made the transition to compensation work easier. The first plant systems followed this example but, in recent years, have spread out beyond "first aid," accident prevention and examinations for employment to complete medical service to employees and their families. This step brought the industrial physician into sharp and subsidized competition with the private practitioner and led to bitter conflicts in many localities.

From a multitude of similar statements the following quotation is taken as typical of the reaction of the private practitioner toward this tendency.¹⁶⁷

"Instances of the abuse of corporation practices, in so far as their medical departments are concerned, continually come to hand. On a previous occasion we have been required to speak about the corporation physician who treats professionally, on the company's time, employees complaining of headache, toeache, and all the aches in between, at no cost to the employee, despite the latter's salary of \$1,500 up to \$6,000 and beyond.

166. Stevens, Harold W.: Address before New England Medical Council, *New England Journal of Medicine*, Nov. 13, 1930, p. 974. National Industrial Conference Board: *Medical Supervision and Service in Industry*, 1931, pp. 3-5.

167. "It Stinks," editorial, *Delaware State Medical Journal*, May, 1930, p. 87.

When in addition to free professional services the doctor dispenses gratuitously medicines from the corporation stock-room the pharmacist has a legitimate kick to register.

"From another quarter we hear complaints about the corporation physician who gives anti-hay fever injections, etc., gratuitously to employees. By no stretch of the imagination can a corporation claim that working in their office has caused the hay fever, produced an asthma, or caused a severe anemia, yet the company's doctor (we hope unwillingly) gives serum treatments free. . . .

"Now one's medical sense of the eternal fitness of things, to say nothing of the ethics involved, has reached an abysmal depth when a salaried corporation doctor usurps the patient's inalienable right of free choice of physician, even though there may have been no actual duress. Such a functionary has no moral or ethical right whatsoever to even suggest a consultant or a hospital, for the element of potential duress is always present. . . .

"This rank usurpation by corporate medics of the rights of free choice and of private practice has another angle: it is just one more step towards the socialization or the nationalization of the medical profession, than which no worse calamity could befall the public. Slowly, but insidiously, corporations, lodges, and associations are rendering the field of medicine less and less competitive, and unless this tide be stemmed the day of the individual private practitioner is doomed."

The new development has not lacked defenders. It is claimed that industrial practice is a legitimate and important specialty of medicine, justified by the neglect of industrial phases of health and disease by private practitioners. The value of care by an industrial medical department in conserving the health of the workers and reducing the hazards of employment has been stressed, and certainly it cannot be successfully denied. No criticism can be rightfully directed against those who have shown the close relation between occupations and health. All this is largely arguing outside the question that is really at issue. It is not a question of the value of industrial medicine but of the methods of organizing and applying it. The questions at issue are not medical, surgical, therapeutic or sanitary but social, economic and financial.

The medical service is not requested by the prospective patients. The whole history of the attitude of organized labor on this point shows hostility to the establishment of such systems. They were established.

as most of the writings defending them admit, to cure financial ills of the employer rather than physical ills of the employee.¹⁶⁸

When an industrial plant medical service is introduced and controlled to reduce the costs of production and increase the profits of an enterprise, these motives must inevitably warp judgments in diagnosis, treatment and prognosis of recovery. The physician who knows that the support which his work will receive from his employers is primarily dependent on financial rather than medical standards must be more than human not to permit these considerations to govern important phases of the treatment of his patients.

These prospective patients are practically never given any choice in the selection of the physician but are often called on to pay for his services through pay-roll check-offs.

It is the confusion of these issues that has muddled much discussion. It is argued that the plant physician or contract medical service returns the employee to work in less time than the private practitioner. This point has already been discussed but may well be considered from this new angle.

The Industrial Accident Commission of California presents the following table of comparisons of time lost in 26,851 cases of contract and 69,494 of private treatment:¹⁶⁹

Private Doctor Paid a Specific Fee

1914 Average time lost in days.....	20
1915 Average time lost in days.....	19
1916 Average time lost in days.....	18
1917 Average time lost in days.....	17.41

Company Hospital or Contract Doctor

1914 Average time lost in days.....	15
1915 Average time lost in days.....	14
1916 Average time lost in days.....	14
1917 Average time lost in days.....	14

^{168.} Of twenty-three titles cited in a bibliography prepared by the library of the National Bureau of Casualty and Surety Underwriters, eighteen stress the financial advantage of health service in industry. On attitude of organized labor, see Williams, Pierce: Medical Care Through Fixed Periodic Payment, 1932, p. 3, note by Hugh Frayne.

^{169.} Report, 1917-1918, p. 177.

This example illustrates many things besides the fact of comparative rapidity of restoration to the job. Some of these will be considered shortly. This can be better done if we first set alongside this table some other opinions of the same commission. In the early days of compensation, the same body said of contract practice:¹⁷⁰

"There has been noted in the last fiscal year an ever increasing tendency toward 'contract practice' among the insurance companies. This is a most deplorable condition since the contracts are frequently made with men of poor equipment and some whose only equipment appears to be a willingness to work for little money. One great failing in this contract work is that treatment and results of treatment are seldom subject to comparison or supervision. There is a tendency toward 'surgical inbreeding' in that a man, secure in his exclusive care of the cases of some insurance company, may do pretty much as he pleases as long as he is acceptable to the company. The result is *poor work*.

"Very often has contract practice brought to this office cases for inspection by our Medical Department. These injured men present themselves for the purpose of satisfying their doubts as to the results or character of the treatment they have received.

"These examinations frequently result in change of doctors or exactions of satisfactory treatment by the insurance companies.

"On the other hand were the work shared among all well-equipped physicians, there would be a general interest, mutual discussion and stimulation which go to produce a high order of treatment and results."

Place beside this another comment only a few years later:¹⁷¹

"Probably the most serious problem is that of medical treatment of the injured. Medical treatment includes physical therapy, occupational therapy and work treatment, as well as surgical and medical services. The greatest single cause of prolonged disability following injury is neurosis in its various phases. Medical treatment has more influence on the development of, or avoidance of, neurosis than any other one mutable factor.

"We foresee in the rapidly increasing tendency of the members of the medical profession to join medical service organizations and to produce wholesale medical service, a danger of increase in neurosis.

170. Report 1916-1917, p. 21.

171. Report 1922-1923, p. 17; 1915-1916, p. 25.

"Treatment of those with nervous tendency, requires, we believe, more individual insight than the wholesale method of treatment is prepared to yield. It is true that a mass of patients passing through a medical institution whose morale is kept high by successful surgeons, kindly and patient attention, and above all that contagious spirit of confidence which sometimes is epidemic among patients, will do much to overcome the harmful elements in wholesale medical service.

"We deplore the fee cutting and contract work which organized medical service appears to entail."

Evidently the human mechanism is not fitting into the processes of the assembly line in such a way as to produce the best results. It may seem unkind to point out that we have here another example of the layman's confusions and contradictions when he attempts to combine his medical ignorance with his social and economic knowledge. Such confusions and contradictions always arise when conflicting medical and economic definitions of disease and treatment are combined in the same chain of logic. It is the failure to see that restoration to the job is not always identical with restoration to health, that the necessity of industrial specialization in treatment does not prove the necessity of certain economic and social forms of organization of that treatment, and that the economic and social forces thus introduced should not necessarily determine the character of the medical treatment, that are the main defects in such logic.

Unless the dangers of this confusion of definitions are kept clearly in mind, much of the discussion of the expansion of contract practice in connection with compensation which is to follow would not be clear, and many of the arguments for and against such extension would appear to be entirely beside the point.

The development of the industrial plant medical system was given an especial impulse by the peculiar provisions of the compensation law in a number of Western states. Owing to the industrial importance of mining, lumbering and construction works in these states, the plant medical department had a powerful influence in determining the character of compensation legislation. Most of these schemes supplied complete medical care to their employees and sometimes to their families and were supported by a "check-off" on wages.

Clauses perpetuating and legally enforcing this situation were made a part of the compensation law in these states.¹⁷²

It will be noted that the first effect of these laws was to place the burden of the cost of medical care under compensation, which in other states was borne by the consumers, on the employees. There had long been strenuous objection by the employees to this "check-off" from wages for medical service. The objection was by no means confined to the cash deduction but extended to the character of the service.¹⁷³ In fact, there are few subjects on which it is so easy to collect such a mass of denunciatory material as on the character of contract and industrial medical service. Labor journals, official investigations, industrial commission reports, are as emphatic, and well-nigh unanimous in condemning such service as perfunctory, neglectful, hasty and superficial as are any of the medical journals, which the defenders of such services charge with prejudice. Even after the largest reasonable allowance is made for such prejudice, the indictment is too specific and unanimous to justify any other conclusion than that in spite of brilliant examples of excellent services, so frequently cited, the general standard must be decidedly poor.

This general criticism has not prevented the rapid growth of such systems in most of the states where they were encouraged by favorable provisions in the compensation law. The entire structure of the Washington law seems especially designed to foster such contracts.¹⁷⁴

"To resume, ours is not an employer's liability act. It is not even an ordinary compensation act. It is an industrial insurance statute. Its administrative body is entitled the Industrial Insurance Commission. All the features of an insurance act are present. Not only are all remedies between master and

172. Bulletin 423, U. S. Bureau of Labor Statistics, September, 1926, for wording of such laws in each of the states. Bulletin 304, August, 1922, pp. 35 et seq. for discussion of provisions of Washington law. Workmen's Compensation Act of the State of Montana, Industrial Accident Board Report, 1926, Nevada Industrial Commission Regulations, April 1, 1931, p. 1. Sixth Annual Report Industrial Commission of Colorado, 1921-1922, p. 10. Boyd, James Hamilton: Workmen's Compensation, 1913, p. 13. Williams, Pierce: The Purchase of Medical Care Through Fixed Periodic Payment, 1932, pp. 96 et seq.

173. Third Biennial Report of the Department of Labor and Industry of Montana, 1917-1918, pp. 10 and 55. On attempts of employers to avoid provisions of similar laws designed to prevent shifting of compensation costs to employees, see Report Industrial Commission of Colorado, 1921-1922, p. 11.

174. Opinion Supreme Court of Washington, Stertz et al vs. Industrial Insurance Commission, Report Department of Labor and Industries, 1924, p. 18.

servant abolished, and, in the words of the statute, all phases of them withdrawn from private controversy, but the employee is no longer to look to the master even for the scheduled and mandatory compensation. He must look only to a fund fed by various employers. When the employer, for his part, pays his share into this fund, all obligation on his part to anybody is ended. . . .

"Under our statute the workman is the soldier of organized industry accepting a kind of pension in exchange for absolute insurance on his master's premises."

Washington has the exclusive state fund plan of administering, not only compensation insurance, but all other phases of compensation. The working of the system is explained by E. S. Gill, Supervisor of Industrial Insurance.¹⁷⁵

"The state of Washington has the exclusive state plan, or state monopoly on industrial insurance and medical aid. The industries for medical aid purposes are divided into five classes. I want to say first that the insurance in Washington is collected on the pay roll, being based upon a certain percentage of pay roll. The medical aid is based upon the day's work, and the industries are divided into five classes, according to the hazard of the business, for the purposes of medical aid contributions, classes A, B, C, D and E, and one-half of the cost of medical aid is paid by the employer and one-half by the employee. This act calls for a payment of 1 cent for each day's work or a fraction of a day where it is equal to half a day or over; class B, 1½ cents a day; class D, 2½ cents a day; and class E, 3 cents per day. . . .

"We have, as I said, the state plan, but employers and employees are permitted under our law to contract with doctors and surgeons for the treatment of the employees, but under a state supervision. I might say also that we have had a good deal of trouble with the contract, because of the abuse largely through the contract doctors. It is simply human and natural that the man who has a contract, when the claimant is brought into his hospital, takes the contract to make money out of it, and the first thing he thinks about is how soon he can get this man out of the hospital. So at the last session of the legislature we secured an amendment to the contract feature of the law which gave the supervisor of industrial insurance almost autocratic power over contracts as well as state cases. He is now empowered to require the filing of a bond by all contract doctors for the faithful carrying out of the work, and is also granted power and authority in cases of emergency to transfer

175. Bulletin 304, U. S. Bureau of Labor Statistics, August, 1922, p. 35. The contributions required from employees for medical aid have been greatly increased since this statement was made. Some classifications pay from 15 to 18½ cents weekly, and the minimum is 2 cents. Medical Rate Sheet, Department of Labor and Industries, July 1, 1932.

the patient from the contract doctor to the care of another doctor at the expense of the contract doctor and the man's employer. Also, he may, of his own volition, after a hearing, cancel any contracts that may be in effect. We found that it was necessary to secure this amendment because of many abuses under the contract system, which had cost the industrial insurance fund thousands of dollars."

An illustration of the abuses which it was hoped this amendment permitting more stringent regulation would abolish is furnished by a quotation from the Report of the Department of Labor and Industries: ¹⁷⁶

"In Nos. 165945 and 167093 one man received a comminuted fracture of the tibia and fibula of the leg and the other received a fractured hip. In both cases the employees were under a medical contract made by the employer.

"Neither employer appeared to take any interest in the employee following his injury and the treatment in both cases was such that the one receiving the comminuted fracture of the tibia and fibula later had to have his leg amputated at another hospital in Seattle and the man receiving the fractured hip had to have additional bone surgery performed at the Tacoma clinic. The result is that the cost to the industrial insurance fund in these two cases will be in excess of \$2,000 each, and worse than that is the fact that both men will be permanent cripples."

Hamilton Hyday, a member of the Industrial Insurance Commission of Washington, in a pamphlet on the "Treatment Cost of Work Accidents," described further abuses:

"There are hospitals in this state which have heretofore indulged in the practice described by Chairman Pratt of aiding and abetting in coerced settlement, giving the man a drink of whisky and a railroad ticket to a distant point, thereby being relieved of further responsibility for hospital care and stopping inroads on the hospital's potatoes due to the man's returning health.

"One corporation in southwest Washington arranged with the hospital to have all medical and hospital treatment given it stipulated average of 130 men for the sum of \$300 a year. The company then deducted regularly \$1 per month or \$1,560, leaving a net balance on the books of \$1,260 for its enterprise!"

In spite of this provision for closer regulation, the industrial commission has never seemed to accomplish

¹⁷⁶ Bulletin Department of Labor and Industries of the State of Washington, September 1921. See also Northwest Medicine, October 1931, p. 468.

much in controlling and regulating contract medical practice. Perhaps the explanation is found in the quotation from Supervisor Gill. All the economic motives are against good service. The easiest way for the commission to make a good record for economy and efficiency is by reducing the cost of medical care and thereby lowering premiums to the employer. The employer buys his medical service where he can buy it the cheapest, and the quotations just given show that the doctor who takes the contract protects his interests by giving inferior service.

A similar, but by no means identical, development has been going on in a number of other compensation jurisdictions. In New York the first point of crystallization seems to have been around clinics and advertising doctors specializing in compensation practice. The insurance carriers created their own clinics or contracted with chains of clinics specializing in compensation practice. That the underlying objective of these organizations was financial and economic rather than medical treatment is shown by the fact that the greatest attention of the physicians engaged seems to have been given to the treatment of the compensation commission rather than the injured worker. If this seems a maliciously facetious attitude, listen to the report of an official investigation.¹⁷⁷

"In a considerable proportion of the examinations, the carriers' representative is physically, not professionally, present. It might even be true to say that he is no more than fiscally present. He is in or near the examining room but pays scant attention to the examination or to the findings of the state doctor, except to ask what they are so that he may note them on his report to the insurance carrier and collect his fee for 'attending' the examination. In cases where the injury is such as to make a large award likely, the physician representing the carrier does watch the examination and discusses with the state doctor the findings which he has made. In such cases the carrier frequently brings in specialists. There is thus a danger that the opinion of the state doctors may be influenced by arguments from the carrier's representatives. The problem then boils down to this: The presence of the carriers' physicians is in many cases useless, when it is not useless it is vicious. It should, therefore, be prohibited by law."

177. Rogers, Lindsay: *Investigation of Administration of the Department of Labor, 1928*, New York Legislative Document 49, 152d Session, p. 135. For reference to similar conditions in Michigan, see Collins, Harrison Smith: *The Relation between Physician and Industry*, *Journal Michigan State Medical Society*, December, 1930, p. 908.

Is it not clear where the "medical" treatment is being applied? The "specialists" are not called for consultation to the sickbed but to the commission's chambers. The examination is not to cure the physical ills of the patient but the "fiscal" complaint of the insurance carrier. The confusion of economics and therapeutics has reached its logical conclusion.

This plan seems to have corrupted the carriers as well as the physicians. The situation is set forth in another official investigation, and covers so many of the disputed points as to deserve the following quotations: ¹⁷⁸

"The State Insurance Fund pays far more attention to getting work for favored doctors than it does in paying compensation to the claimants. For some time the State Fund has endeavored to compel all its employees in the vicinity of New York City to send all workmen to 'State Fund Dressing Stations,' for medical treatment. What are called 'State Fund Dressing Stations' are merely offices maintained by one physician, to whom through this method, the State Fund attempts to send all claimants for such treatment. . . .

"As a matter of practice the physician in most cases is selected by the insurance company. The claimant is thus left in this position, viz., the physician who treats his injuries and restores him to working condition later appears as a witness against him upon his application for compensation. . . .

"It is my opinion that the medical profession generally can be trusted to treat industrial injuries. What appears to be needed in connection with the compensation law is a better organization of the medical profession for the purpose of providing prompt and efficient service in cases of industrial injuries. The state medical societies should be consulted on how this organization can be secured and made effective. The cooperation of the medical profession should result in a revision of the law, which would permit free choice of physicians at least to a limited extent. I believe that some change in the law in this respect is imperative."

As an escape from these evils a committee, appointed by Governor Franklin D. Roosevelt, proposed the establishment of state clinics to handle compensation work. This proposal was opposed by the New York State Medical Society as tending to legalize and perpetuate all the evils it was designed to cure. In defending his proposal, the chairman of the committee has thus

¹⁷⁸ Report Jeremiah F. Conner, Moreland Act Commission, May 27, 1919, Legislative Document 74, pp. 15, 32, 33.

described the old clinic practice, so long defended by the insurance carriers:¹⁷⁹

"While certain of these clinics undoubtedly maintained high professional standards, the average level of medical care is deplorable and, in certain cases, excruciating. It is not uncommon that such clinics are manned by newly graduated students receiving \$25 a week, working a ten-hour day. The use of untrained, unregistered nurses in these clinics has been widespread. In many cases the actual treatment is given by these obviously unqualified operators. Concrete evidence points to the existence of what can only be regarded as a medico-commercial racket in certain clinics.

"Such conditions are a menace to the injured in industry. Further, they do not reflect glory or distinction upon the medical profession itself. Neither the historic ethical traditions of the profession nor the scattered individual efforts of upright members of that profession have proven adequate to cope with these conditions."

It would be easy, but tiresomely repetitious, to show how similar conditions have arisen in many other states.¹⁸⁰

Always there are the same complaints of inferior service, of physicians perverted from their professional care of patients to financial care of employers and carriers and of attacks on professional standards at vital points.

This was but the preliminary stage to a development that even now is in full swing in but a few places but the germs of which are visible in many more localities. When a multitude of individual plant and carrier medical systems of the character described have come into being, the stage is set for the appearance of the medico-economic promoter to seek to eliminate further economic cost by a process of consolidation.

This promoter came into a field where the expansion of contract practice had already gained such a momentum that it had spread far beyond the bounds of compensation. Hospital associations, often originating in compensation work, but now reaching into other fields, lodge practice and other semi-health insurance schemes

179. *New York Sun*, May 17, 1932.

180. Report of committee on Compensation and Health Insurance, Texas State Medical Society, *Texas State Journal of Medicine*, June, 1925, p. 88; *ibid.*, June, 1931, pp. 98-101; Walker, R. H.: *The Gorgas Idea Applied to Industrial Medicine and Surgery*, *West Virginia Medical Journal*, July, 1928, p. 327; "Contract Practice," *West Virginia Medical Journal*, August, 1929, p. 490. *Am. College of Surgeons "Survey of Medical and Hospital Service in W. Va."*, *ibid.*, January, 1933, pp. 1-14; Leland, R. G.: *Contract Practice*, *J. A. M. A.*, March 3, 1932, pp. 808-815.

were ready for his activities. Organizations were formed to take contracts for all forms of industrial and group practice. Solicitors are sent out to solicit business and overpromise and underbid competitors. These phases are already well developed on the Pacific Coast and all the conditions for their appearance are found in a multitude of localities throughout the country. We have now reached the stage which was so prophetically described in the report of the Judicial Council of the American Medical Association in 1915.¹⁸¹

"Some form of workman's compensation law has been already passed in more than half the states in the Union, and there is small doubt that before long such laws will have been passed in the majority of the states if not in every state. The passing of these laws does not mean that some new or special law has been passed to compensate an injured workman under the old common law system, but it means an entirely new legal and social conception of compensation for injury and is, in fact, the beginning of a new social and economic condition in this country. These new economic conditions affect very materially the medical men in a community. It is certain to bring up the questions in new forms of contract and lodge practice, of health and accident insurance, of state aid and state medicine. It will also affect the relationship between the boards of trustees and the attending physicians and surgeons in private and municipal hospitals."

In Washington and Oregon, at least, contract practice, centering around compensation, has developed to a point where it threatens at once the economic and the ethical foundation of the profession. Some features of the existing situation are described in a statement of H. J. Davidson, chairman of the Committee on Public and Industrial Relations of King County, Washington. He says of "contract doctors":¹⁸²

"They hire laymen to solicit the contracts, thereby diverting a considerable portion of the fund to channels of commercialism and, as a corollary to the medical aid law contracts, contract doctors are carrying on a wildcat health insurance business. They are known to have paid up to 20 per cent of the gross revenue derived from the contract and up to \$600 a month to lay agents, through whom the contracts were secured. Through the use of hired lay agents they secure contracts remote from their home towns, then sublet to local doctors for 25 per cent of the total revenue, their sole service being to secure and to

181. Proceedings, House of Delegates, A. M. A., 1915, p. 13.

182. Northwest Medicine, January, 1931, pp. 47-48; October, 1931, p. 468.

sublet the contract, or they hire the cheapest available local doctor to render service under the remote contracts and often require him to pay them 50 per cent of the gross revenue derived from all private practice developed while in their employ.

"In some instances a local physician has secured the necessary signatures to the petition intending to take over the contract for the industry. Remote organizations hearing of the fact, through influence they could bring to bear, caused word to be sent to the mill that the employees should rescind their signatures immediately or if necessary every employee would be fired and an entire new crew hired. In these instances the workman contributed 50 per cent of the revenue and under the law are supposed to have equal authority with the employer, regarding who shall do their medical work under the Medical Aid Law. A remote group of physicians are so entrenched that they are able to take the bread and butter from the mouths of laborers, their wives and children unless the medical aid contract is awarded to them. The workmen have grievances on this score and about the adequacy and efficiency of the services to the injured, but they dare not protest.

"The group of workmen included under the medical aid law contracts comprise convenient groups to bring into the wildcat health insurance activities. For from seventy-five cents to one dollar and fifty cents a month, contract doctors agree to render all professional services and pay all costs incident to the care of accidents not included under the medical aid law and all sicknesses with specific limited exceptions. This contract is a limited health and accident insurance policy with all the evil possibilities of wildcat insurance, to wit:

1. The contract doctor is the insurer.
2. The insurer is unsupervised as to financial resources, and as to performance under his contract.
3. He determines the rates, administers the insurance fund, determines what services shall be rendered, renders that service personally or through agents in his hire, and retains the unexpended portion.

"Any insurance actuary will testify to the fact that the rate is utterly inadequate. Every man operating would go bankrupt in a short time, if he fulfilled the terms of the contract. Any unprejudiced physician will testify to instances of failure of the insurer to fulfil his contract.

"A man with a perforating ulcer of the duodenum went nine times to the contract doctor. The eighth and ninth times he was so ill his son had to take him after refusal of the contract doctor to call at the home. No adequate history was obtained, absolutely no examination was made. He was given a box of pills, some ten cents in value, which proved so laxative that their use had to be discontinued. He then consulted his family

physician, who rendered proper service, including hospitalization and operation, incurring some \$400 expense. The contract doctor wilfully and negligently evaded financial obligation, the professional responsibility and effort to save for himself the cost of hospitalization and special nurses.

"The ideals and ethics of the medical profession have through all time paralleled very closely those of the legal profession. The Legal Practice Act of the State of Washington specifically prohibits the use of hired lay solicitors for securing professional work for lawyers. It is declared to be against public policy. The Medical Practice Act does not contain any similar clause, although seventeen states and territories do have laws prohibiting the practice, with revocation of license as the penalty."

Against this indictment, the defenders of contract practice make the customary claims of the superiority of the service given by industrial specialists.¹⁸³ There does not seem to be any attempt to defend the practices of solicitors, the expense of administration and profits to lay managers or the methods by which employees, who in this case are paying in part directly for their own medical service, are denied all freedom of choice.¹⁸⁴

A description of the expansion of this contract service beyond the field of compensation into a system of general health insurance is given in a paper by Alexander H. Peacock,¹⁸⁵ read before the Spokane County Medical Society:

"For some time there has been a rider to the industrial contract, called the supplemental health contract. Mines, mills, lumber camps and railroads find such service almost indispensable. Due to low wages, these workers save practically nothing. Often, too, they are itinerants or drifters. They carry their worldly goods on their shoulders. The state requires accident insurance but no medical or sickness insurance. An additional fee held out of their wage covers all illness. Formerly they were a burden on the county or local community when they became ill. Under full coverage, they become self supporting in illness as the cost is distributed over the whole group.

"This type of sickness insurance has found a ready response among others than industrial workers, as clerks, truck drivers, office employees, dairymen, restaurant workers, department stores, garages and oil stations. All indications point to its rapidly spreading to all low wage earners. At the present time

183. A. Macrae Smith, President of the Society of Industrial Surgeons of the State of Washington, *Northwest Med.*, January, 1931, pp. 48-49.

184. "Under this section we have seen 64 men sign a contract that within the next couple of months tied up ten thousand to the contract; in another case sixteen hundred men within a short period of time tied up fifteen thousand." *Seventh Annual Report Industrial Insurance and Medical Aid Department of Washington*, 1919, p. 84.

185. *Northwest Medicine*, February, 1932, p. 89.

it constitutes voluntary health insurance. With our low income depression, this type of sickness protection is eagerly sought by the various hospital associations, benefit associations, industrial or group clinics. The average fee charged seems to be one dollar per month for each insured person. It constitutes only partial medical insurance but is better than no coverage at all. There are several groups who are waging an active campaign to write this business. A number of them offer the service only to the workman himself but there is strong pressure being brought to include the family. Sickness in the family of the low wage earner is almost as serious as that of the breadwinner. . . .

"The hospital and beneficial associations collect an industrial and insurance tax from each workman. Instead of employing doctors on the state schedule fees, they employ them on a salary. We found doctors on a salary of \$150 per month doing \$800 or \$900 of service on the standard fee charges. This averaged thirty-three cents a call, house or office, with all surgical work thrown in free of charge. This work took three fourths of their income. Dressings, office assistants they furnished themselves.

"Another plan that is being worked is for the hospital association to solicit the contracts at a dollar per month per head, and then assign the medical service to a clinic or groups, at eighty cents or less. It has been suggested that some of these hospital associations who employ solicitors or managers are only a blind for the clinic receiving the service end of the contract."

Here is a system of health insurance, as large as is to be found in some European systems, containing most of the evils and few of the merits of such systems, which has grown up almost without notice, subject to no effective governmental supervision and almost independent of the influence of organized medicine. Nor does the evolution in the states of Washington and Oregon differ from that going on in other states save in the fact that it has proceeded further and faster than elsewhere. The state compensation authorities are encouraging this latest extension. In a special circular sent by the Washington authorities to employers, the latter are advised that "a group sickness and non-occupational accident policy should be carried," as this will reduce the amount of compensation by leading the employee to trust to such a general policy rather than to demand compensation.

This evolution has proceeded almost automatically as a resultant of the various interests involved. Those interests so far have been almost entirely economic.

Only incidentally have scientific and professional interests had any influence. The dominant determinants have been the employers and the carriers. Later the administrators have sought ease and economy in operation. Developments have now proceeded to where the managers of medical contracts are moving on their own initiative to a defense of the interests that have been created. No matter how undesirable solicitors, managers and contract physicians may be in relation to the care of the workers or the progress of the medical profession, the stage has been reached at which those who profit by the system look on their rights as "vested" and worthy of a determined defense.

Organized medicine in Washington has from the beginning exposed and denounced the abuses of contract practice and sought to discourage its extension but has produced little effect. It is now so strongly entrenched that recent efforts have been directed toward restricting the most flagrant abuses. A committee of the Washington State Medical Association, after a year's study of the subject, made the following recommendations to the meeting of the House of Delegates in September, 1932:

"The Committee submits the following changes in the Industrial Aid Act, with regard to contracts:

1. A board of physicians, selected by the State Industrial Commission and the Washington State Medical Association, to determine the capabilities of the physician for handling contracts.
2. To give to the State Industrial Board the power to accept or reject contracts on a basis of competence, honesty and remoteness of the contract; the right to judge whether or not the applicant can give a high quality of service.
3. Contracts to be granted only to physicians licensed to practice in the State of Washington—actually practicing in the state and giving personal supervision.
4. The Medical Aid Fund to be paid to the contracting physician according to the going rate of that class. This is to avoid rebating. No doctor shall have financial interests in a company with which he has a contract.
5. Supervision of supplementary contracts by the Industrial Insurance Board. Under this supervision, the establishment of a minimum rate per month for the supplemental contract in consultation with the Washington State Medical Association; also the rule that a supplemental contract cannot be held unless same physician holds the industrial contract.

6. Contracts to be made only with those physicians who agree to operate them, and not with the corporations or laymen.
7. Non-industrial contracts. Any person holding himself out as treating the sick for a specific sum per month or per year shall be declared to be in the insurance business, and shall be required to submit the conditions of his contract to the insurance commission and to give bond for the proper performance of his contract. This shall not apply to contracts dealing with men who are engaged in extra-hazardous occupations coming under the Industrial Insurance Commission.
8. Solicitation of contracts by lay solicitors would be corrected through modifications in the New Medical Practice Act."

Conditions in Washington have been described at some length because they are repeated with slight changes in Oregon and California, while several other states are traveling the same road only a few years behind Washington.

CHAPTER IX

SUGGESTED CONCLUSIONS AND RECOMMENDATIONS

Knowledge of industrial environment is a help in diagnosis and treatment. So is a knowledge of heredity. But it does not follow that an adult's ancestors should choose his physician. The economic relation of employer or insurance carrier does not confer ability either to give or to judge medical treatment. It is more apt to create a conflict of interests that positively unfits for any such function.

The principle has a wider application. Because an organization functions well as an employer or insurance carrier it does not follow that it is suited to operate a medical service. On the contrary, forcing the personal relations of patient and physician into the mold of an industrial organization is very apt to distort and destroy the most valuable features of those relations.

A large percentage of the evils that have grown up in compensation medical practice can be traced to efforts to produce medical service with instruments primarily intended to produce other goods and profits. It is somewhat as if a packing house should try to produce cutlery or a foundry to turn out legal services without changing equipment. The character of the desired product must be the determining factor in any organization, and the success of the organization is judged by its product. The product aimed at by an efficient system of medical care is such personal relations of the patient with the physician as will best restore and maintain health, and any such system must center around this objective. Every question that comes up must be decided according to this test.

Apply this test to some controverted points. It may be, and probably is, true that industrial surgery calls for some specialization. But getting a job with an industrial establishment or an insurance carrier is not a test of competence as an industrial surgeon. Experience has amply shown that it is far more often a test of ability to meet certain economic and financial qualifications. The applicant is apt to be judged far more

according to the salary he will accept, his ability to reduce labor turnover and willingness to provide the sort of testimony that will keep down compensation payments than by his educational background and professional attainments.

After he is hired, if his relation to his patients is forcibly determined by their economic position as employees, and if his ability to hold his position is determined in any degree by his success in keeping down the costs of compensation and reducing lost time, then to just that extent his professional actions are rendered an imperfect instrument for the production of good medical service. He must bend his scientific judgments to his economic interests as a very condition of survival, and he will be the more strenuous and sincere in so doing the more he becomes unconscious of these influences.

The harm that proceeds from such situations spreads far beyond those immediately subject to its conditions. Compulsory patronage by patients creates a condition of "unfair competition" such as has been made criminal even in many fields of business. It is not simply that the physician in many forms of contract practice is driven to actions that have always been condemned by his profession. The very fact that patients come to him by compulsion and not by free choice makes it impossible for him to judge himself or to be judged by his fellow practitioners and the public according to those comparative standards the attainment of which has been the greatest incentive to professional progress.

This isolation is especially harmful to this very specialty of industrial medicine. The ablest, most professionally ambitious and conscientious of its practitioners constantly complain of the indifference of the profession and medical schools to the significance of industrial causes of disease. It can never be otherwise so long as compensation practice is a closed corporation dominated by economic motives and maintained by compulsory patronage. Physicians outside the closed circle who note the increasing dominance of economic considerations and the rapid growth of such undesirable forms of contract and clinic practice as have been described come to look on compensation practice as a threat to all medical ideals and to the existence of the individual practitioner. They will therefore tend to underestimate the importance of industrial relations on

disease and its treatment. They will oppose the introduction of such subjects into the curriculums of medical schools so long as compensation practice is so closely monopolized in forms repugnant to traditional medical ethics as to make such education of little benefit to the profession as a whole.

This very attempt to make the effects of occupation on health a specialty confined to those in "industrial practice" is itself another sample of the confusion of economic and medical thinking. To the extent that occupational conditions affect health and medical treatment they are a concern of every physician attending any one having an occupation. But those who speak of this specialty seem to imply that its practice is limited to those physicians who are employed by an industrial concern.

The judgment of the "chosen" and that of the "excluded" are thus almost equally warped by economic outlooks. Emotional reactions and financial interests distort scientific attitudes on both sides. These attitudes tend to divide the medical profession and thereby to reduce its influence in determining the form of compensation institutions. As this condition crystallizes and the industrial phase grows it develops its own standards, establishes its own institutions and translates its adopted customs into its own codes of ethics.¹⁸⁶

In these codes of ethics an attempt is made to combine the old standards with the new conditions. But the problems of practice under the relations and institutions that have grown up in compensation practice are not the same as those encountered in private practice. One writer has sought a solution by saying, "Physicians and employers both must realize that industrial medicine is, in a measure, a compromise between the ideals of medicine and the necessities of business."¹⁸⁷

But such compromises are often dangerous and sometimes impossible because neither economic conditions, industrial relations nor "business necessities" can

186. See California and Western Medicine, March, 1926, pp. 374-375, for code of ethics "Applicable to Industrial Medical Practice" (Professional services rendered under terms of the Workmen's Compensation, Insurance and Safety Act) adopted by the House of Delegates, at Yosemite, May, 1925, codified by the Council, January 30, 1926. Delaware State Medical Journal February, 1932, p. 56, for code adopted by Wayne County (Detroit) Medical Society.

187. Selby, C. D.: Studies of the Medical and Surgical Care of Industrial Workers, U. S. Public Health Bulletin 99, 1919.

change anatomic, physiologic or therapeutic facts. After all, the physician is not treating "compensation cases" but ailing persons.

This division within the profession is not the least of the evils arising from an effort to arrange "a compromise between the ideals of medicine and the necessities of business." Once that division has arisen, it becomes a valuable "vested interest" of powerful commercial and industrial organizations that seek to foster and encourage its development. It would be but aiding and abetting their efforts to cite instances in which the efforts of state medical societies to abolish some of the evils of compensation practice were thwarted by the efforts of those who "rode to the meeting on passes" to defend the interests of employers. Nor does it help matters any to quote the claims of these favored ones that their opponents were motivated by "jealousy" of those criticized.

Such mutual recriminations prove nothing either as to the sincerity or the scientific justification of the position of either side but they do excellently illustrate at once the difficulty and the necessity of separating economic motives from scientific discussion of professional problems. It was not a mere coincidence that in an investigation by a committee of the State Medical Association of Washington the percentage of affirmative replies to the question of favoring contract practice was almost identical with that of the physicians engaged in such practice.

That such a division of professional forces will be harmful to both sides, and most of all to the public, will be readily admitted. Yet there is danger that this cleft will be widened still further through the efforts of the economic interests that hope to profit by such a division, just as it was widened by similar developments in some European countries until there arose a separate economic medical organization. In the European experience, the economic organization, no longer backed by a united profession, became more and more helpless to defend itself against the encroachments of "business necessities" until it was almost the literal slave, economically and scientifically, of business interests.

Nor is the lesson of European experience any more gratifying to the opponents of those engaged in contract and other forms of industrial practice. As such

practice expanded, the physicians in private practice dwindled to an insignificant and almost starving percentage of the profession.

Experience supports logic in the conclusion that no help can come from further compromise between economic motives and scientific standards. It is better to "render unto Caesar the things that are Caesar's" and to confine the inevitable changes in social and economic relations as far as possible to their proper fields, while the human and scientific relations between physicians and patients, already tested by persistence through centuries of such social changes, continue to be judged by human and scientific standards.

This is no counsel of perfection, impossible of attainment. It is in just such states as Ohio, Massachusetts, Maine, New Jersey, Wisconsin, Utah and a few others where there has been the least interference by lay industrial organizations in the setting up of medical institutions in compensation practice that there is least friction and least complaint by all concerned. Neither employers, carriers nor medical promoters have ever even attempted to show that conditions in these states, even measured by economic standards, are not to be preferred to those prevailing in states with a multitude of lay controlled clinics, contracts and hospital associations, or where the medical service is in any other way dominated by employers and carriers. In these states the ground is fairly clear for the establishment, should such action ever be thought desirable, of any special medical arrangements for handling compensation practice. Such institutions can be set up by, and under the control of, the medical profession, for the single purpose of furnishing the best available medical service in compliance with scientific and ethical standards.

The question of whether specialized education and training is needed for compensation practice is a scientific and not an economic one. If standards of qualification are to be set up for this purpose, they should be set up by the medical profession and not by employers or insurance carriers, and be based on education, training, experience, skill or such other qualities as make for greater ability to treat the sick or injured, but the "necessities of business" have no place among such standards.

1. There should be absolutely free choice of physician or surgeon by the injured worker among those compe-

tent to give the services required. That competence should be determined by professional standards and not by financial considerations.

2. There should be no solicitation or compulsion exercised on patients to compel them to enter into any scheme of medical care. Any deviation from this rule means that medical qualifications and consequent medical care are made subject to financial considerations.

3. All expenditures for medical care should go to those who give that care. There is no excuse for the presence of the profit taking promoter, organizer or entrepreneur between the physician, surgeon, nurse, hospital or other agent giving such care and the patient who receives it. Every attempt to introduce such a third party has been proved wasteful and harmful.

4. There should be medical representation in all compensation institutions proportionate to the medical interests involved. Questions of a purely medical nature should be passed upon by those who have met the standards set up by law to determine medical qualifications and who alone have been pronounced capable of passing on such questions.

5. It is important that in every state medical society there should be an active committee devoted to the study of the problems of industrial medicine. Wherever compensation laws exist, this committee should be in close and continuous contact with the administrators of compensation, to the end that medical subjects be presented from the scientific professional standpoint and that all physicians may be kept fully informed of any questions at issue.

6. There should be greater consideration for the human side of accident prevention programs and the active participation of physicians in such work.

7. It is suggested that efforts be made through joint action of state medical societies and the compensation authorities to establish more equitable and uniform fee schedules.

The fifth suggestion is really the only essential one and implies all the others. This study has shown that the form of legislation and institutions is of far less importance than their administration. If that administration is monopolized or dominated by the interests that are concerned primarily in conserving the income of employers and carriers, then the medical care of the

injured workers and the professional standards on which that care so largely depends will be neglected, not so much through direct intent as through indifference, neglect and overemphasis of the interests actively and intelligently concerned in such management. If the medical profession is continuously and thoroughly conscious of its responsibilities and opportunities, if to its undisputed monopoly of the scientific knowledge of medical diagnosis and treatment it adds an equally thorough knowledge of the best economic, political and social methods of applying that knowledge to the situations that arise under competition, the many illustrations already given prove that the public and even the employers and carriers will be willing to listen, and even to follow, the counsel of the organized medical profession.

CHAPTER X

CHANGES DURING 1933, 1934 AND FIRST HALF 1935

The period since the publication of the first edition of "Medical Relations under Workmen's Compensation" has been a time of steady development of tendencies noted in that edition. There has been a general expansion of coverage, increase in the amount of compensation, extension of medical facilities and care, and a general liberalization of the provisions of previously existing laws. This movement has been irregular and sporadic. The changes have been scattered over many states but when the picture is viewed as a whole a fairly regular progress in definite directions is noticeable.

Florida, one of the four states not having a Workmen's Compensation law, is the only state in which, during this period, an original Compensation law was enacted. This law was passed in 1935 and follows the general pattern of Compensation Laws which previously existed, except in the far western states. Only three states are now without Compensation laws: Arkansas, Mississippi and South Carolina. Twelve states now extend coverage to occupational diseases; the extent and method of that coverage still differ widely. Greater attention is being given to rehabilitation. Several of the states which have previously limited medical care, either to a definite period or to a specific amount, have liberalized these limits.

It will be noticed that nearly all of these changes have increased the importance of medical care in relation to compensation. This is a continuation of the evolution toward increasing the importance of the function of the physician, a tendency which has steadily grown in importance since the beginning of the Compensation legislation.

From the medical point of view the most important and clearly defined development has been the growth in knowledge and consequent increase of the influence of organized medical opinion. State medical societies have strengthened the influence and effectiveness of the medical profession on matters pertaining to com-

compensation by creating and maintaining continuously energetic well informed committees of the state medical societies, devoting their attention to medical problems under compensation. The result has proved the wisdom of this policy, especially when contrasted with the procedure, which had been previously followed by many state medical societies, of seeking to promote desirable or to defeat undesirable legislation. Such legislative efforts were necessarily more or less spasmodic. They usually depended on a legislative committee which had no specific interest in compensation problems and which could be effective only at the time the legislature was in session. Occasionally efforts were made to influence general elections. These efforts usually sprang into activity only after laws that were considered unsatisfactory had been introduced or were confined to the support of bills introduced on the advice of the medical profession. Such tactics resulted in the lineup of opposing forces and more often than not in the defeat of the medical objective.

When a permanent State Committee on Workmen's Compensation is created it is possible for the State Medical Society to make continuous contacts with carriers, employers and labor organizations and to work out problems of administration by a process of discussion and sometimes mutual concession. The medical profession goes into such conferences with almost a monopoly of information on medical matters. The very force of the facts argue on the side of the medical profession. As a consequence of this situation greater progress has been made during the last two years in adjusting and improving medical relations and the medical care received by the injured workers than had been obtained in the previous decade.

This development does not involve the conclusion that efforts of the medical profession to change undesirable laws should be abandoned. It does seem to indicate that greater success in such legislative action is obtained when it is preceded by a program of education and helpful cooperation.

These discussions have often culminated in legislation long desired by the medical profession but which had been hitherto opposed by the other elements concerned. This is especially illustrated in the developments in New York State which will be described later.

It has taken nearly 20 years of constant struggle on the part of organized medicine to obtain correction in a few of the states of some of the worst abuses that were introduced into practically all of the states by the original compensation legislation. It would be hard to find a better illustration of the evil effects that follow the attempt to introduce even a limited form of compulsory sickness insurance connected with cash payment under lay control. It is today impossible to measure the amount of human suffering and injustice that some of this legislation unwittingly created. That these evils are, to some extent, being removed is in no way due to the efforts of politicians, officials or insurance carriers. On the contrary, in practically every instance these groups have fought, in the beginning at least, every effort to change the laws and practices responsible for these abuses. Only when the organized medical profession has finally been able to present a body of unanswerable arguments and to demonstrate conclusively that even the financial interests of its opponents would be improved by greater extension of professional control of medical service, has it been possible to begin to mitigate these abuses.

No attempt has been made in the following pages to argue the merits of the questions involved nor, except in a few cases, to discuss in detail the results. Instead, quotations are given illustrating developments in a number of states and a few localities within other states, where actions of state or county medical societies have brought about or promise to accomplish important changes in the provision of medical service under compensation.

Arizona.—An editorial in *Southwestern Medicine* contained the following statement concerning a proposal submitted under the Initiative and Referendum Law to abolish the Arizona Industrial Commission.¹

It is difficult to see how any impartially minded physician or surgeon in the state can support this measure. The policy of the Commission has always been one of cordiality and fairness to the medical practitioner. They made a poor start in the outset of their organization when, under the guidance of a legal adviser trained in California, a fee schedule similar to the one in that state was announced. However, when these fees were protested by the Arizona State Medical Association,

1. *Southwestern Medicine*, Vol. 16: 10, October 1932, p. 433.

they were invited by the Commission to write their own schedule. A special meeting of the Association was called, met in Phoenix, and worked out the present schedule; although this was more generous than can be found in any other state, it was adopted by the Commission. At the same time, the Association was requested by the Commission to appoint an advisory committee to confer with the Commission over any differences which might arise between that body and individual practitioners. Such a committee was appointed but failed to function when called on, so that the Commission was forced to work out its medical problems the best way it could.

It appears from the editorial that the differences arose under "cases in which the Commission acted as insurer" and where personal conflicts arose concerning the character of the medical service and fees charged. The Initiative was defeated.

The Arizona State Medical Association later adopted the following resolution:²

Resolved, By the Arizona State Medical Association that a permanent Industrial Relations Committee of five of its members be established; that said Committee be known as the Industrial Relations Committee of the Arizona State Medical Association; that the president of the State Medical Association each year automatically become a member and chairman of this Committee and that the other four members of said Committee be appointed by the President of the State Medical Association within a period of thirty days following the adoption of this resolution and that said members so appointed serve for a period of one year or until their successors have been appointed; that said Committee be representative of the medical profession of the state, and be fully authorized to represent the membership of the State Medical Association in all questions and decisions relative to medical relations under workmen's compensation: that said committee be further authorized to form its own organization and regulations, and be further authorized to enter into any arrangements or agreements with the Industrial Commission of Arizona, which, in the judgment of said Committee may aid in carrying out its purposes; that said Committee keep a record of its activities and make annual reports to the Arizona State Medical Association; and be it further

Resolved, That the Arizona State Medical Association, through its Secretary extend greetings to the Arizona Industrial Commission, enclosing a copy of this resolution, together with the names of the members of the Committee so appointed, and further to advise the Industrial Commission of the desire of the physicians and surgeons of the state to cooperate with

2. *Southwestern Medicine*, Vol. 18:9, September 1934, pp. 317-318.

said Commission insofar as their special knowledge and experience may be of value to the Commission in administering the Workmen's Compensation Law.

The Committee was appointed and held its first meeting July 1, 1934.³ It succeeded in constructing a satisfactory fee schedule to become effective, August 15, 1934. It took up numerous other controversial questions with the Industrial Commission at this and subsequent meetings and secured satisfactory adjustments. The Commission also presented questions of a medical character to the Committee for opinions, and seems to have been guided by the opinions rendered. In order to keep the medical profession of the state informed on the work of the Committee, the Industrial Commission agreed to publish a Bulletin following each meeting of the Committee. The Committee agreed to prepare for publication in the Bulletin full reports and discussions of its meetings. The Bulletin of the Arizona Industrial Commission for August 1934 describes the meetings with the medical committee and the results of the discussions, and expresses approval of the cooperation received from the Arizona State Medical Association.

California.—There has been considerable criticism of an attempt of the State Compensation Insurance Fund to reduce the existing medical fee schedule from 25 to 50 per cent.⁴ The State Fund also tried to restrict the choice of physician and to introduce undesirable forms of contract practice. There has been also considerable complaint of fee cutting and contracting by other insurance carriers. The principal complaint, however, was against the State Fund which does about 40 per cent of the business and has returned nearly 20 million dollars in dividends to policy holders. It is freely charged by the physicians that this record has been made possible largely through insufficient payments to physicians.⁵ A report of the Committee on Industrial Medicine through the Council of the California Medical Association says:⁶

3. *Southwestern Medicine*, Vol. 19: 3, March 1935, pp. 98-99.

4. *California and Western Medicine*, Vol. 42: 5, May 1935, p. 396. Graves, John W.: *State Compensation Insurance Fund*, Bulletin Los Angeles Medical Society, Jan. 18, 1934, pp. 37, 59, 68.

5. Advertising Circular issued by the Fund entitled, *State Compensation Insurance Fund Is Your Fund*.

6. Typewritten copy, p. 7.

"The industrial Medical situation is not alone critical; it is disagreeable and dirty. Within the ranks of our own profession are intrigue and connivance. There is no loyalty to group and no adherence to standards. Every man is for himself and the devil take the hindmost."

Colorado.—The Colorado State Medical Society's special Committee on Workmen's Compensation Affairs recommended that legislation be advocated to allow every member of the State Medical Society who is qualified in Industrial surgery to serve injured workmen under the Compensation Law, in contradistinction to existing regulations, whereby compensation work is assigned by the Industrial Commission to a small list of chosen surgeons. This section of the report was endorsed by the House of Delegates.⁷

District of Columbia.—The Compensation, Contract and Industrial Medical Committee on Medical Economics and Workmen's Compensation Practice of the Medical Society of the District of Columbia has made a study of the conditions of practice under Compensation and has developed policies to remedy some of the existing evils.⁸

*Massachusetts.*⁹—The Public Relations Committee of the Council of the Massachusetts Medical Society met with the representatives of the insurance companies, and as the result of these discussions the Medical Committee made the following recommendations:

(1) As the employers have paid premiums for the care of the workingman's injuries, it is unreasonable to expect that doctors inside or outside of hospitals should take care of those cases without pay and that we should ask that a patient sufficiently injured to need hospitalization should be recommended to a hospital as a *private patient*. We affirm that nurses and other agents should act only under the authority of the physician in charge of the case. Both the insurance companies and the doctors should be primarily interested in the early return of that patient to his work with as good a functional result as could be obtained. We believe that that principle is better

7. Colorado Medicine, April 1933, Vol. 30:4, pp. 160-161.

8. Typewritten report of the Committee, Feb. 6, 1935; Medical Annals of the District of Columbia, April 1934, Vol. 3:4, p. 107.

9. Report of the Public Relations Committee, undated proof, 1933.

business both for the insurance companies and the injured party, the hospitals and the attending doctor.

(2) The doctors and the insurance companies should both welcome consultations, and we are assured that the insurance companies *do*, for the benefit of the injured party. If the medical profession is free to treat the individual on a minimum fee basis as he does in private practice unhampered by bickerings and dissensions, the patient will probably make an earlier and better recovery.

(3) We should be solicitous of the fairness of our charges. It is highly probable that with this principle in mind, excessive operative fees and frequent and unnecessary visits would be eliminated. Major operations, except as an emergency measure, demand a consultation with Insurance Company.

(4) As regards the two weeks' treatment, it is reasonable to assume that if the insurance company is informed, as it should be, as to the nature of the disability, there will be little question raised if the treatment extends over a longer period than the two weeks covered by the law. A record should be kept by the physician from the time of the accident or disability to the discharge of the patient. There has been in existence over a number of years an admirable report and office record for such cases that has minimized misunderstanding on either side and which we recommend as an efficient instrument for use in such cases.

In discussion of the relation of the private physician to the industrial accident case, we are solicitous of the maintenance of the physician's rights and believe in whatever instances may arise that an ambulatory patient should be referred to his own physician, if such he has.

(5) We believe that the Accident Board, composed of lay and legal individuals, is handicapped in having to base their findings so largely on conflicting medical evidence and that through the establishment of a board of impartial medical examiners, who would examine the individual, make a diagnosis of his condition together with a prognosis of his disability and classify him in relation to his ability to undertake his work; and make a written report to the Industrial Accident Boards of these factors, the end results would be more satisfactory to the Industrial Accident Board and to the Insurance companies and would materially lessen the cost of administration and the number of cases in dispute.

(6) Many physicians of high standing are not interested in industrial accident work because of the disputed bills and the demands upon their time incident to attendance on prolonged hearings before the Board, in relation to some trivial, it may be, case. We believe that a plain statement of fact, an affidavit of the individual's condition and his capacity for work, should be acceptable to the insurance companies and the Accident Board.

(7) We have discussed the question of limitation of fees to any one case but believe that that is susceptible of abuse by either party, the doctors or insurance companies, and that it may be deferred if it indeed at any time seems feasible.

It is our belief that in the principle of friendly intercourse as between individuals, much of the distrust and lack of understanding that have led to legislation in the attempts to iron out the difficult and vexatious question arising can be better met just as the individual differences of neighbors can be eliminated through friendly relationships, inspiring confidence and understanding, rather than through the use of legal machinery in which to an alert and highly trained man there are always possible loopholes for evasion, if such be the intention.

Michigan.—The Committee on Industrial Relations of the Wayne County Medical Society "has been charged with the duty of acting as counsel and arbiter in cases of dispute and misunderstanding involving the doctor and his industrial relations."¹⁰

This Committee has also approved a "Code of Ethics for Compensation Cases" which is used as a guide in settlement of questions of practice.¹¹

Missouri.—The Committee on Medical Economics of the Jackson County (Kansas City, Mo.) Medical Society submitted a report which was adopted by the Executive Council, December 5, 1933.¹² This report recommends that a permanent Committee of the Jackson County Medical Society be called the Committee on Industrial Relations.

The Committee shall cooperate with representatives of Insurance carriers, employers, employees, State authorities, etc., to the end that the Arbitration Committee, consisting of members from such groups as may be necessary, is formed. This Arbitration Committee shall review all matters of controversy arising between the various groups involved.

The Committee is also to make a study of all legislation and regulation that affects the practice of industrial medicine, and act as a grievance committee to

10. Bulletin Wayne County Medical Society, Sept. 20, 1932, pp. 5-20.

11. Bulletin of the Wayne County Medical Society, April 12, 1932, p. 6.

12. Jackson County Medical Journal, Vol. 27:50, Dec. 16, 1933, pp. 3-7.

investigate any unprofessional acts in relation to industrial practice.

New York.—New York State has long been characterized by more than the average amount of controversy over the operation of Workmen's Compensation. Numerous legislative investigations have exposed abuses in the medical service connected with the administration of the law. The agitation centering around these abuses has grown sharper during the last two years.

A Committee of physicians, appointed by Governor Herbert H. Lehman, summarized the condition as follows:¹³

The law has not worked to the benefit of the working man as well as had been anticipated. He often fails to obtain adequate medical care. Racketeering has become notorious. Unscrupulous and inefficient industrial clinics, not infrequently controlled by laymen or unethical physicians, are able to conspire within the law with unscrupulous employers and insurance carriers to obtain for themselves, by means of rebates, the privilege of treating injured workmen. Medical service rendered under these circumstances is usually inferior. In order to secure additional income and to cover the cost of the rebate or commission, treatment has been needlessly prolonged and bills for medical services have been excessive. The cost of insurance to the honest employer has been thereby increased and insurance carriers have been unable to estimate accurately the actuarial risk so that they have lost money on Workmen's Compensation and Insurance.

This report then lists the evidence in support of each charge in the above indictment, and then recommends a number of changes in the law including a fee schedule, free choice of physician (subject to certain restrictions) the formation of a panel of physicians to be selected and supervised by the County Medical Society, and a series of regulations to control solicitation and to maintain professional ethical standards.

The Medical Society of the State of New York and various County medical societies conducted further investigations and presented reports on the measures necessary to correct the evils that had developed.

On March 28, 1935, a new law known as "The Medical Abuses Act" was signed by the governor and became effective.¹⁴ This law provides for the prepa-

13. Report of the Committee on Workmen's Compensation, appointed by Governor Herbert H. Lehman, p. 3.

14. Chapter 258, Laws of 1935. Text found in the *New York State Journal of Medicine*, Vol. 36: 9, May 1, 1935, pp. 510-516.

ration of a State minimum fee schedule, for greater freedom of choice than had previously existed and that "the Commissioner shall upon the recommendation of the medical society of each county or of a board designated by such county society, or by a board representing duly licensed physicians of any other school of medical practice, authorize physicians licensed to practice medicine in the state of New York to render medical care under this chapter. If, within sixty days after the commissioner requests such recommendations, the medical society of any county or board fails to act, or if there is no such society in a county, the commissioner shall designate a board of three qualified physicians who shall make the requested recommendations."

This law seems to be the result of several lines of evolution, nearly all of which had their origin in the active and intelligent leadership of organized medicine in New York.

Ohio.—An investigating committee was appointed by the Governor of Ohio in 1934 to study the operation of the Workmen's Compensation Law. This committee worked in close cooperation with the Ohio State Medical Association.¹⁵

The Commission pointed out that the medical staff and facilities at headquarters are inadequate for thorough examination and the expeditious handling of the work, and your committee believes that in some cases the staff is lacking in qualifications, and the present medical system is seriously in need of revision to the end that prompt and adequate medical attention may be given claimants, and just as prompt settlement of claims may be had. The checking up of hospital cases, hospital services and charges, as well as doctor's services, has been inadequate.

It also discovered that irregularities in the reporting of payrolls were "said to have defrauded the compensation fund of approximately one million dollars." (It will be recalled that Ohio has an exclusive State Insurance Fund.)

In May 1933 the Council of the Ohio State Medical Association recommended a series of changes to eliminate "abuses on the part of some physicians, hospitals, nurses and claimants." It was also "urged that regular

15. Ohio State Medical Journal, Vol. 31:1, March 1935, pp. 203-208.

medical boards of review be set up to review and pass upon chronic, prolonged, unusual and revived cases; that in flagrant cases of abuse and fraud prompt prosecution be instigated by the Commissioner under the fraud sections of the Workmen's Compensation Law; that a plan be devised whereby medical organizations can furnish confidential information to the Medical Division on cases of suspected malingering, questionable cases and on the character of and professional standing of physicians suspected of promoting abuses.¹⁶

In 1935 the Governor's Committee, previously mentioned, endorsed most of the above recommendations. Its recommendation number 2, proposed a reorganization of the Medical Division, the principal feature of which was the addition to the Commission of a "medical chief with assistants." This recommendation is so comprehensive and so completely in accord with the attitude of the medical profession that it deserves quoting in full.

"As a result of our investigation and the experience of your committee, it appears that in at least 80 per cent of the injured cases compensation or non-compensation depends upon medical judgment, which obviously should be as competent and sound as possible. As the Commission itself cannot be expected to form judgments concerning the proper treatment of injuries, nor to determine the disabilities or the extent of disabilities arising out of injuries without expert assistance, your committee is of the opinion that the Commission is in need of a highly competent medical chief, a man not specialized in one line or another, but one of wide general experience, of high character, having executive capacity and temperamentally qualified to deal fairly and efficiently with the medical fraternity in general. He should be qualified to conduct or have conducted, researches concerning occupational disease and other disabilities, and to organize and direct the entire medical personnel and procedure under the general direction of the Commission. He should be qualified and have the power to select, with the approval of the Commission, all other members of the medical staff regularly employed and others who may be selected from time to time as specialists for the purpose of special examinations. He should be employed by and subject to removal by the Industrial Commission, and should be paid enough to warrant his leaving his private practice.

"The chief medical officer should direct and supervise hospitalization and rehabilitation. He should be held accountable for prompt and proper medical examination of the injured, for

16. Ohio State Medical Journal, Vol. 30: 3, March 1934, pp. 171-173.

the competency and efficiency of the staff, and for the economical though thorough operation in general of the medical division. With the approval of the Industrial Commission he should have the power to dismiss medical members of his staff. Your committee cannot emphasize too strongly the importance of this position in the matter of doing justice to the injured avoiding delays and appeals, and saving a great deal of expense to the fund."

The third recommendation of the Commission is to provide for a Medical Board of Review to pass on medical testimony and contested cases. It also urged that greater attention be given to rehabilitation.

Oklahoma.—The situation in Oklahoma is much like that which existed in a majority of the states only a few years ago. This state has a State Insurance Fund that apparently follows most of the undesirable features of private carriers, including some which the private carriers have rejected in many states. The situation is summarized in a discussion by Dr. Aisenstadt at the time the report of the Committee on Contract and Industrial Practice was submitted to the House of Delegates of the Oklahoma State Medical Association, May 22, 1934. He then made the following statement:¹⁷

"As a member of that committee which submitted this report I should like to make a few remarks. That report was presented when we thought something might be done relative to the activity of the State Industrial Fund or State Insurance Fund. Since that time I have had personally some connection with the manager and find it will be impossible to make any headway with him. The state manager of this insurance fund is splendid material for a young bureaucrat in that he is self sufficient and does not particularly care to receive any information or advice. So far as I know, this young man has had no experience in insurance at all, or no experience in taking advice. They ignore the medical profession. They do not care about the doctor and do not fear him. The state insurance seems to be surrounded by people of that kind. Their attitude is this: If they think you have given one or two or three or four treatments more than you should they are going to cut your bill, regardless of the fact that they didn't see the case and don't know what complications came up. I recently had a check submitted to me by the insurance fund in payment of a bill of \$10.50. The check was in the amount of \$10.00. I demanded

17. Journal of the Oklahoma State Medical Association, Vol. 27:7, July 1934, pp. 267-268.

to know why the bill was cut fifty cents and the reply was that if I didn't like it I didn't have to do their work. It is not a question of reducing a bill for two hundred dollars or three hundred dollars, but of reducing a bill of \$10.50 to \$10.00. I have sent in bills of \$5.00 and \$6.00 and \$7.00 and every one was cut down without any explanation, except that if I didn't like it I didn't have to do the work. Mr. Knapp's attitude is terrible. I have taken the matter before the State Industrial Commission. Judge Doyle said: 'If you don't like it you don't have to do the work.' The State Insurance Fund should be completely and forever divorced from the State Industrial Commission and should be handled through an entirely different agency. The State Insurance Fund is put in operation to provide as cheap an insurance as possible and to give as much protection as possible to the employee. It is not the purpose of the State Insurance Fund to make money. The state is not entitled to profit on that fund, yet Mr. Knapp and his Commission try to make a name for themselves and save the State of Oklahoma a lot of money and in their effort to do that they are making money on the State Insurance Fund. They don't care about you and about me, and what are you going to do about it, because they are entrenched behind a mighty safe law, safe for the Commission of course, prepared by the Chairman of the State Industrial Commission, and they are settled there to stay. You can get that changed only in one way, by legislation, and by legislation only in one way, and that is by taking advice and taking interest in politics and seeing that your legislature members will listen to your pleas, and have this changed. Without that you have started State Medicine. We have the beginning of State Medicine now in the State Insurance Fund, an organization controlled by laymen telling you doctors how many treatments you can give, how and when and where and what you are going to charge. If that is not the beginning of State Medicine, what is it?"

The report of the Committee was adopted by the House of Delegates of the Oklahoma State Medical Association.

Oregon.—The Oregon State Medical Society has been working in close cooperation with the State Industrial Accident Commission, and has succeeded in negotiating an agreement with that Commission.¹⁸ This agreement provides:

"1. Until July 1, 1934, the commission will be paid according to the existing fee schedule of the commission less a 12.5 per cent discount.

18. *Northwestern Medicine*, Vol. 39: 8, Aug. 1934, pp. 294-295.

2. On July 1, 1934, the commission will discontinue publication of a fee schedule and the Oregon State Medical Society will publish and circulate among the medical profession a minimum industrial fee schedule. . . . During the period July 1, 1934, to October 1, 1934, physicians will be paid according to this schedule less a 25 per cent discount.

3. On or about October 1, 1934, the Commission will prepare data showing the experience of the previous three months' period of operation under this plan and will meet with the Committee on State Industrial Affairs of the Oregon State Medical Society for the purpose of reviewing results and reaching a more permanent agreement based on the findings derived from this three months' experience.

4. The Oregon State Medical Society will investigate any irregular practices and excessive bills of physicians and will aggressively discipline any member found to be engaging in such practices.

5. The Oregon State Medical Society reaffirms its approval of the Liaison Committee to consult with the Commission from time to time concerning padded bills and other irregularities by physicians and will, when requested, submit a list of members from which the Commission may select such Liaison Committee." . . .

Under the new agreement, the level of physicians' compensation is raised approximately to that prevailing prior to the reduction in fees made by the State Industrial Accident Commission in 1931. The Commission has been most cooperative in working out this agreement. In accepting our official schedule as a base schedule, the Commission indicates its desire to bring up the compensation of physicians to a reasonable level.

It will be noticed that this provides for continuous cooperation between the Oregon State Medical Society and the State Industrial Accident Commission and makes possible the prompt adjustment of any differences that may arise, or at least for their careful consideration, in joint meetings where both sides can be fully presented.

The provisions of the Oregon law that encourage contract practice in connection with Workmen's Compensation have had some important recent developments. The Workmen's Compensation Law provides that:

It shall be lawful for an employer to collect or deduct a portion of the wages of his employees for medical, surgical or hospital care and attention in such amount and in such a manner as may be reasonable.¹⁹

19. Workmen's Compensation Law, published by the State Industrial Accident Commission of Oregon, 1933, pp. 36-37.

There are various provisions as to the control of this fund and its maintenance as a trust fund. Another section of the same law provides that "it shall be lawful for the employer to make contracts with regard to the funds of his employees collected" under the previously quoted section of the law. This law established contract service as an integral part of the Workmen's Compensation Law. It also deviates from the practice, in the majority of states, by which the burden of medical care is placed on the employer and permits that burden to be shifted to the employee. In accordance with this provision, "hospital associations" (which usually have no connection with hospitals) have been formed. These are required to have a minimum paid up capital of \$5,000 and to sign a bond of \$10,000. In the year 1933, there were twelve such "hospital associations" operating in the state of Oregon, most of which were operating for profit, soliciting patronage and giving a service that caused much complaint.²⁰ They had an annual income of \$852,723.

The competition of these associations has been steadily crushing out private practice in the industrial field and to a certain extent lowering standards of medical practice in all fields.

In 1932 the Multnomah County Medical Society sanctioned the Multnomah Health Association, which attempted to enter into competition with the "hospital associations." "The Multnomah Health Association" was organized by members of the Multnomah County Medical Society and was formed as a method of defense. It has entered into contracts under the provision of the law quoted above. At the same time it has maintained the freedom of choice of physicians who are members of the Association and it is generally agreed that a better grade of service is being furnished by this Association than by the private "hospital associations." However, the rates fixed in the law and which have been crystallized in the pattern of the private "hospital associations" necessarily had to be followed by the "Multnomah Health Association." These rates were too low to permit adequate payment to the physician under any form of organization unless he

²⁰ Twenty-Sixth Annual Report of the Insurance Commission, 1934, p. 33.

undertook to care for so large a number of persons that the service would inevitably deteriorate.

Pennsylvania.—It is doubtful if compensation legislation and administration in any state has been subjected to as thorough study from as many points of view as that of Pennsylvania during the last two years. In 1933 the Governor appointed a committee on Workmen's Compensation which held hearings in various sections of the State and presented a report. Later in the same year an advisory committee, including some of the members of the Governor's Committee, continued this investigation. In 1933 and 1934 this investigation was continued and greatly expanded with the aid of a large number of workers who were paid through the Civil Works Administration of the Federal Government.²¹ In all of these investigations the Medical Society of the State of Pennsylvania was active. A Committee on Workmen's Compensation laws was appointed by the President of the State Medical Society in 1934 which not only made individual investigations but supplied material for the more extensive investigations mentioned above.

This comprehensive study of the subject confirmed the criticism and conclusions which organized medicine has made not only of the Pennsylvania system but of similar systems in other states. It demonstrated that control of medical service by interested lay individuals and corporations resulted in inferior service and that physicians and hospitals were inadequately paid for such service as was given. The recommendations of the Committee of the State Medical Society were endorsed in substance by the Governor's Committee.²²

The Philadelphia County Medical Society formulated an agreement with the Insurance Carriers.²³ This agreement places the responsibility for control of the qualifications of physicians, who are to treat compensation cases, on the County Medical Society, which will also prepare a fee schedule which "shall be a guide to

21. Outline of Needed Changes in Pennsylvania Workmen's Compensation System; Special Bulletin No. 40, Part 1A, pp. 5-7. See also The Results of Workmen's Compensation in Pennsylvania, Special Bulletin No. 40, Part 1B and 1C; Self Insurance with Workmen's Compensation in Pennsylvania, Special Bulletin, No. 40, Part 2.

22. Pennsylvania Medical Journal, September 1934, Vol. 37:12, pp. 1082-1083; Vol. 38:2, Nov. 1934, pp. 99-102.

23. The Weekly Roster and Medical Digest, June 3, 1933, Vol. 28:40, pp. 27-28.

the treating physicians in preparing all bills for service." Further provisions are:

The Philadelphia County Medical Society further agrees that it will participate in the creation of a joint committee of physicians and carriers, to act as an Arbitration Board, for settlement of disputed bills between physicians and carriers. This Committee shall consist of two members of The Philadelphia County Medical Society and two representatives of the carriers. No arbitrator shall sit in any case in which he or the party he represents is interested. Any physician submitting to arbitration shall abide by the decision of the Board.

The carriers agree to waive the question of authorization for family physicians who are members of the Philadelphia County Medical Society and who will comply fully with the agreed plan of the Philadelphia County Medical Society and carriers. Reasonable charges for services of such physicians will be promptly paid.

Washington.—The provisions in the Washington Compensation Law, permitting and encouraging contract medical practice, have led several of the county medical societies to form "medical service bureaus" in an effort to retain as many as possible of the features of private practice. Other objects of these bureaus formed by county medical societies are to provide a better medical service than is furnished by the private contractor and to assure a wider freedom of choice of physician by the employee.

The fact that the law encouraged the formation of "full coverage contracts," which not only provided for care for compensable injuries to the employees but extended the full medical service not only to employees but also to their families, made such defensive action on the part of organized medicine appear to be necessary.

King County Medical Service Bureau (Seattle) was formed in 1932 and is the largest of these bureaus. While it is claimed that the service offered by the bureaus operated by the County Medical Societies is better than that furnished by private contractors, it also remains a fact that the standard of rates, fixed by private associations, and the competition with these associations makes it impossible to charge such monthly dues to contributors as is required for the maintenance of a high grade of medical service.

West Virginia.—There have been important changes in the medical relations of Workmen's Compensation in West Virginia. The law has been liberalized by the provision that silicosis shall be made a compensable disease. A "Workmen's Compensation Silicosis Fund" was created with special administration, though subject in its general provisions to the administration of the general Workmen's Compensation Fund. There is to be a medical board known as the Silicosis Medical Board, consisting of three licensed physicians with special knowledge of pulmonary diseases.

For many years the West Virginia Compensation Law has had one provision which has been especially attacked by the medical profession. What happened to this section of the law is described in the following extract from the Report of the Legislative Committee of the West Virginia State Medical Association.

We are particularly proud of our report on the 1935 regular session, if for no other reason than the fact that it marks the successful culmination of a fight which organized medicine has been making for twenty years. Our reference here, of course, is to the passage of the liberalized workmen's compensation bill with which most members of the association no doubt are familiar by this time. The work of the Association Legislative Committee was primarily directed toward amending Subsection (c) of Section 3 of Article IV of the old law so as to divorce by statute compensable injuries from the operation of list hospital practice. Under the old law it was possible for hospitals and employers to make contracts which embraced not only hospitalization but also medical treatment for compensable injuries as well as family sickness, and this practice was so generally carried out that list hospitals, particularly in southern West Virginia, had a monopoly on treatment of compensable injuries, but neither the hospital, the members of its staff, nor the general practitioner received remuneration for services performed in treatment of compensable cases, where the injured employee was a list subscriber.²⁴

This victory of the West Virginia State Medical Association blocks the growth of a phase of contract practice that, had it been permitted to be extended, might have created a situation analogous to that existing in Oregon and Washington.

Wisconsin.—There have been no important changes in the Wisconsin Compensation Law. The State Medi-

²⁴. West Virginia Medical Journal, Vol. 31: 6, June 1935, pp. 286-288.

cal Society of Wisconsin has devoted its energies on Workmen's Compensation largely to securing an expansion of the "panel system" already in existence. This system was intended to provide a wide freedom of choice by requiring the insurance carriers to name a panel of physicians in each locality instead of confining all of the work to one or a few physicians in each locality. Some of the insurance carriers and employers were practically evading the law by naming such small panels as to permit very little choice. The State Medical Society of Wisconsin, by conferences with carriers and employers, has succeeded in securing agreements by which all qualified physicians may be included in such panels. Arrangements are now under way by which much of the responsibility for naming the members of such panels, and of determining the competency of the physicians included, devolves upon the County Medical Society.

APPENDIX A

Medical Provisions

(Blank Space in Column Indicates No Change)

State	1915	1920	1925	1930
Alabama.....	No law	60 days, maximum \$100		
Alaska.....	Maximum \$150, in fatal cases only without dependents		1 year for injury, maximum \$196 in fatal, without dependents	
Arizona.....	None	None	90 days. Commission may extend. No monetary limit	
California.....	90 days. Commission may extend. No monetary limit	No limit, time or amount		
Colorado.....	80 days, maximum \$100	60 days, maximum \$200		4 months, maximum \$500
Connecticut.....	Unlimited time or amount			
Delaware.....	2 weeks, maximum \$25	2 weeks, maximum \$75	30 days, maximum \$100. Board may require further treatment	
Dist. of Columbia.	No law	No law	No law	No limit, time or amount
Georgia.....	No law	(1921) 30 days, maximum \$100		
Hawaii.....	14 days, maximum \$50	No time limit, maximum \$150	No limit, time or amount	
Idaho.....	(1918) No limit, time or amount			
Illinois.....	8 weeks, maximum \$200	8 weeks, maximum \$200. Excess necessary to cure	No limit, time or amount	
Indiana.....	30 days. No monetary limit	Ind. board may order additional 30 days		
Iowa.....	2 weeks, maximum \$100	4 weeks, maximum \$100. Commissioner may order \$100 more	Maximum additional \$200	
Kansas.....	None, except no dependent fatal cases	50 days, maximum \$150		60 days, maximum \$100. Additional \$100 may be ordered
Kentucky.....	(1918) 90 days, maximum \$100	90 days, maximum \$100. Additional \$100 may be ordered by board		
Louisiana.....	2 weeks, maximum \$100	Maximum \$150. No time limit	Maximum \$250. No time limit. For hernia, maximum \$250	Hernia provision omitted
Maine.....	(1916) 2 weeks, maximum \$30	30 days, maximum \$100. Time and amount subject to extension		
Maryland.....	No time limit. Maximum \$150	No time limit. Maximum \$300	No time limit. Maximum \$500	
Massachusetts.....	2 weeks. Board may extend.			

Montans.....	2 weeks, maximum \$50	.....	6 months, Maximum \$500, plus hernia operating fee \$50	60 days, maximum \$750 Hernia fee \$100
Nebraska.....	3 weeks, maximum \$200	No time limit. Maximum \$200	No limit, time or money	
Nevada.....	4 months. No monetary limit	60 days, may be extended to 1 year. No monetary limit	6 months, may be extended to 18 months. No monetary limit	
New Hampshire....	No provision	.....	14 days. No monetary limit	
New Jersey.....	2 weeks, maximum \$50	4 weeks, maximum \$50. Bureau may order additional	No time limit, maximum \$50 for physician's service; \$50 for hospital	Bureau may extend
New Mexico.....	(1917) 8 weeks, maximum \$50	2 weeks, maximum \$50	10 days, maximum \$150	No time limit. Maximum \$350
New York.....	60 days. No monetary limit	Subject to extension	No limit, time or money	10 weeks, subject to extension.
North Carolina....	No law	No law	No law	No monetary limit
North Dakota.....	No law	No limit, time or money		
Ohio.....	No time limit. Maximum \$200	Commission may extend		
Oklahoma.....	15 days. No monetary limit	60 days, maximum \$100		
Oregon.....	No time limit. Maximum \$250	Subject to extensions		
Pennsylvania.....	14 days. Maximum \$25. Major operation, maximum \$75	30 days, maximum \$100. Exclusive of hospital treatments		
Porto Rico.....	No law	No law	No law	No limit, time or money
Rhode Island.....	2 weeks. No monetary limit	4 weeks. No monetary limit	8 weeks, maximum \$200	8 weeks, maximum \$150
South Dakota.....	(1917) 4 weeks, maximum \$100	12 weeks, maximum \$150	.....	12 weeks, maximum \$200
Tennessee.....	No law	30 days, maximum \$100		
Texas.....	1 week. No monetary limit	2 weeks. No monetary limit. Board may extend hospital treatment	4 weeks. No monetary limit	
Utah.....	No time limit. Maximum \$200	No time limit. Maximum \$500		
Vermont.....	2 weeks, maximum \$75	2 weeks, maximum \$100	.....	Medical aid 2 weeks, maximum \$50. Hospital 30 days, maximum \$150 Commission may extend to 180 days
Virginia.....	30 days. No monetary limit	60 days. No monetary limit	.....
Washington.....	No provision	Medical aid provided. No monetary limit		
West Virginia.....	No time limit. Maximum \$300	No time limit. Maximum \$600	No time limit. Maximum \$300. Commissioner may add \$600 in permanent disability cases	
Wisconsin.....	90 days. No monetary limit	Commission may extend		
Wyoming.....	No provision	No time limit. Maximum \$100	No time limit. Maximum \$300	
U. S. Federal Employees.....	No law	No time or money limit		
U. S. (Longshoremen Harbor Workers).....	No law	No law	No law	No time or money limit

APPENDIX B

As a check on material obtained elsewhere, and to supplement such material, three questionnaires were used. The first was sent to all secretaries of county medical societies and asked for the following information:

1. Are the present arrangements with respect to dealings between the State Department of Industrial Relations or the State Industrial Commission and the medical profession on workmen's compensation cases satisfactory?
2. If not satisfactory, how could the relations be improved?
3. Did the State Medical Association take any part in forming the state workmen's compensation law?
4. In what other ways has the State Medical Association been actively interested in the state workmen's compensation law?
5. Attach here a copy of the industrial accident and occupational diseases fee schedule.
6. Is this schedule satisfactory to the State Medical Association?
7. If not satisfactory, indicate here the changes that should be made.
8. Are physicians' claims for the care of industrial accidents and occupational diseases settled promptly and fully by your State Department of Industrial Relations?
9. If not settled promptly and in full, what are the reasons for delay in adjustment?

Later the following questionnaire was sent to the secretaries of state medical societies:

1. What official positions are held by physicians in the administration of the workmen's compensation act?
2. What are their salaries, duties and powers?
3. How are physicians concerned with administration selected?
4. Does organized medicine have any voice in that selection?
5. What medical institutions such as clinics, hospital associations, or forms of contract practice have been set up in connection with the administration of workmen's compensation sickness and accident benefits?
6. Is there an official fee schedule? If so, will you please send a copy.
7. What, if any, share did organized medicine have in framing this schedule?

8. If there is no schedule, how are fees determined and is this method satisfactory to the physician?
9. What arrangements are made with hospitals for care of compensation patients?
10. Do hospital surgeons receive fees for work done for such patients?
11. Just what part do physicians take in rehabilitation work done for disabled workmen?
12. What organizations have been created by the medical association to deal with compensation work?
13. Are the physicians generally satisfied with the working of the compensation law in your state?
14. If not, what changes are desired?
15. Have any divisions arisen among the physicians as a result of compensation?
16. If so, what divisions and with what results?
17. Do hospitals caring for compensation cases collect fees for medical service as well as for hospital care?
18. If so, are the medical fees retained by the hospitals or are they remitted to the physicians rendering the services?

In order to verify and supplement the material obtainable from the published reports of state compensation commissions and other administrative bodies, these authorities were asked for the following information:

1. A. Insurance Premiums? B. Compensation? C. Medical Care?
2. Has the Commission a medical department or advisers? If so, what are the functions, duties and powers of such Department or Advisers?
3. How many physicians are employed?
 How many on full time?..... Salaries?.....
 How many on part time?..... Salaries?.....
 How many on fee schedule?.....
4. What relations, if any, exist between the Workmen's State Compensation administrative body and state or county medical societies?
5. If available for distribution, we would greatly appreciate having a copy of your latest report, and any other material bearing on the medical phases of compensation in your state.

APPENDIX C
Official Fee Schedules for Workmen's Compensation

Fractures	Ariz.	Calif.	Colo.	Idaho	Kan.	Md.	Mont.	Nebr.	Nev.	N.Y.	N.C.	Ohio	Ore.	S.D.	Utah	Wash.	W.Va.	Wyo.
Finger.....	\$15.00	\$5.00	\$15.00	\$15.00	\$15.00	\$15.00	\$15.00	\$15.00	.....	\$5.00	\$10.00	\$15.00	\$5.00	\$10.00	\$15.00	\$20.00	\$15.00	.....
Each additional.....	4.50	.....	5.00	4.50	7.50	.....	5.00	5.00	.....	.....	5.00	.....	.....	.....	4.50	.....	.....	.....
Carpal.....	.....	7.50	.....	.....	15.00	10.00	25.00	15.00	.....	25.00	20.00	15.00	20.00	25.00	.....	20.00	20.00	\$25.00
Metacarpal.....	20.00	7.50	25.00	20.00	15.00	25.00	25.00	20.00	\$15.00	25.00	15.00	15.00	15.00	15.00	20.00	20.00	20.00	15.00
Colles fracture.....	.....	.....	.....	20-40	.....	25.00	.....	.....	.....	.....	25.00	50.00	25.00	.....	.....	35.00	50.00	.....
Radius or ulna.....	25-50	12.50	25.00	25.00	25-50	25.00	25.00	45.00	25.00	50-75	25.00	50.00	25.00	25.00	25-50	25.00	25.00	25.00
Radius and ulna.....	50-75	20.00	50.00	50.00	50-75	60.00	60.00	60.00	25.00	.....	40.00	75.00	50.00	50.00	50-75	60.00	50.00	50.00
Humerus.....	50-100	40.00	50.00	50-75	75.00	75.00	60.00	50.00	50.00	.....	50.00	75.00	50.00	50.00	50-100	75.00	65.00	75.00
Clavicle.....	50.00	20.00	25.00	25.00	50.00	25.00	40.00	40.00	20.00	40.00	20.00	20.00	20.00	20.00	25-25	25.00	40.00	50.00
Scapula.....	50.00	20.00	25.00	25.00	20-40	40.00	25.00	40.00	25.00	40.00	20.00	40.00	25.00	40.00	25-25	25-25	25.00	50.00
Toe.....	15.00	.....	15.00	10.00	15.00	20.00	15.00	10.00	.....	5.00	10.00	15.00	5.00	10.00	10.00	15.00	15.00	.....
Each additional.....	4.50	.....	5.00	2.00	7.50	.....	5.00	5.00	.....	.....	5.00	.....	.....	.....	2.00	.....	.....	.....
Tarsal.....	.....	7.50	15.00	.....	15.00	25.00	25.00	20.00	.....	25.00	20.00	15.00	20.00	25.00	.....	25.00	25.00	15.00
Metatarsal.....	20.00	7.50	20.00	15.00	15.00	25.00	25.00	20.00	15.00	25.00	15.00	15.00	15.00	15.00	15.00	20.00	25.00	15.00
Os calcis.....	25-40	.....	50.00	25-75	20.00	.....	.....	50.00	.....	.....	.....	20.00	.....	.....	25-100	25.00	.....	20.00
Astragalus.....	.....	.....	20.00	.....	20.00	.....	.....	50.00	.....	.....	.....	20.00	.....	.....	.....	.....	.....	20.00
Tibia.....	50-75	12.50	50.00	50.00	50.00	50.00	50.00	40.00	50.00	50.00	45.00	50.00	25.00	20.00	50-75	40.00	20.00	20.00
Fibula.....	25.00	12.50	25.00	25.00	25.00	20.00	25.00	20.00	25.00	20.00	25.00	15.00	20.00	25.00	25.00	25.00	25.00	25.00
Tibia and fibula.....	100.00	20.00	75.00	75.00	75.00	75.00	75.00	.....	50.00	50.00	50.00	75.00	50.00	75.00	50.00	75.00	75.00	75.00
Pott's fracture.....	.....	.....	75.00	75.00	.....	.....	75.00	50.00	.....	.....	20.00	.....	20.00	.....	.....	75.00	.....	.....
Patella.....	25-100	20.00	50.00	50.00	50.00	20-50	20.00	25.00	20.00	20.00	25.00	20.00	25.00	25.00	20-100	25.00	25.00	20.00
Elbow or knee.....	50-100	.....	.....	25.00	.....	.....	.....	.....	.....	.....	.....	.....	.....	75.00	50-100	.....	.....	.....

Femur.....	50-150	40.00	100.00	125-150	100.00	100.00	100.00	100.00	75.00	75.00	125.00	100.00	75.00	125.00	100.00	125.00	100.00	100.00
Pelvis.....	50.00	25.00	50.00	50-100	.....	70.00	75.00	75.00	35.00	.....	25-50	.....	25-50	100.00	25.00	70.00	50.00	150.00
Maxilla, superior.....	.....	20.00	.....	.....	15.00	.....	.....	40.00	25.00	.....	15.00	15.00	.....	.....	.....	.....	16.00	15.00
Maxilla, inferior.....	50-100*	20.00	40.00	75.00	40.00	50.00	25.00	75.00	25.00	75.00*	25.00	40.00	20.00	75.00	50-150*	30.00	50.00	40.00
Nasal.....	15-25	12.50	.....	15.00	10.00	10.00	25.00	30.00	15.00	.....	25.00	10.00	10.00	.....	15-50	10.00	30.00	10.00
Cranium, skull.....	50.00	.....	50-100	50-100	25.00	.....	.....	85.00	.....	.....	.....	25-100	.....	75-100	25-75	75.00	75.00	25.00
Ribs.....	10-25	6.00	10.00	10.00	10.00	10.00	20.00	15.00	10.00	5.00	10.00	10.00	10.00	20.00	10-25	10.00	15.00	10.00
Sternum.....	50.00	.....	15.00	.....	.....	10.00	.....	25.00	.....	.....	15.00	.....	.....	.....	.....	10.00	.....	.....
Lumbar.....	50.00	.....	.....	75.00	.....	100.00	.....	.....	.....	50.00	15.00	.....	.....	.....	.....	50.00	.....	.....
Sacrum.....	.....	.....	.....	75.00	.....	15.00	.....	75.00	.....	.....	25.00	.....	.....	.....	.....	15.00	.....	.....
Vertebrae minimum.....	.....	.....	150.00	.....	50.00	.....	.....	125.00	.....	.....	100.00	25.00	.....	.....	50-100	.....	50.00	50.00
Dislocations																		
Shoulder.....	25.00	.....	15-25	25.00	35.00	35.00	25.00	50.00	.....	50.00	25.00	35.00	25.00	40.00	25.00	15-25	35.00	35.00
Hip.....	50-100	.....	50.00	50.00	50.00	45.00	50.00	75.00	20.00	75.00	50.00	50.00	50.00	75.00	50-100	50.00	50.00	50.00
Clavicle.....	.....	.....	20.00	.....	35-50	25.00	.....	.....	.....	.....	15.00	50.00	.....	.....	.....	25.00	35.00	25.00
Knee.....	25-50	.....	35.00	35.00	50.00	25.00	35.00	50.00	.....	50.00	25.00	50.00	25.00	40.00	25-50	25.00	25.00	50.00
Elbow.....	25.00	.....	25.00	25.00	35-50	35.00	25.00	50.00	.....	35.00	25.00	50.00	25.00	40.00	25.00	25.00	25.00	50.00
Wrist.....	25.00	.....	15.00	15.00	.....	15.00	20.00	.....	.....	30.00	15.00	.....	15.00	40.00	25.00	.....	.....	.....
Ankle.....	25.00	.....	25.00	25.00	25.00	25.00	.....	.....	.....	30.00	10.00	25.00	25.00	40.00	25.00	25.00	25.00	25.00
Finger.....	10.00	.....	5.00	5.00	10.00	5.00	10.00	10.00	.....	.....	5.00	10.00	5.00	10.00	10.00	5.00	10.00	10.00
Each additional.....	.....	.....	.....	.....	5.00	.....	5.00	5.00	.....	.....	5.00	5.00	.....	.....	.....	.....	.....	5.00
Toe.....	10.00	.....	5.00	5.00	5.00	5.00	10.00	10.00	.....	.....	5.00	5.00	5.00	10.00	10.00	5.00	5.00	5.00
Each additional.....	.....	.....	.....	.....	2.50	.....	.....	5.00	.....	.....	5.00	2.50	.....	.....	.....	.....	.....	2.50
Lower jaw.....	15.00	10.00	5.00	10.00	10.00	10.00	15.00	5.00	10.00	5.00	25.00	15.00	10.00	10.00	10.00

* Includes dental work.

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