

THE HEALTH CARE **REVOLUTION**

FROM MEDICAL MONOPOLY TO MARKET COMPETITION

CARL F. AMERINGER

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1 The Professional Regime

This chapter traces the evolution of the medical profession from the late 1800s to the mid-twentieth century. Three questions frame the discussion: What factors gave rise to medicine's professional regime? How did the regime exercise its authority? What role did the antitrust laws play in the acquisition and retention of economic and political power?

In discerning the answers to these questions, this chapter stresses the importance of ideas to the development of a profession's identity, its institutions, its internal culture, and its legal authority. Scientific progress in the late 1800s augured progressive reforms; progressive ideology, in turn, advanced the economic interests of physicians and their professional associations. Medicine's success—economic, political, and social—lay in nurturing professional authority vis-à-vis physicians, patients, insurers, governments, competitors, and institutional providers. Professional norms and beliefs, not force, secured physician unity and channeled dissent; legal rules and regulations in support of norms and beliefs aided medicine's domination of the health care industry.

PROGRESSIVISM AND THE MEDICAL PROFESSION

The ideas of progressive reformers were central to medicine's rise to power in the early years of the twentieth century. Progressivism's roots lay in the natural sciences (biology, physics, and chemistry, for example) and the rational, scientific approach to solving problems that these various disciplines employed. Scientific achievement gave rise to numerous inventions—the electric motor, the telephone, the phonograph, and incandescent lighting, to name a few. Medicine benefited as well. Discoveries by scientists and physicians led to sterilization techniques, bacteriology, and X-ray technology.

These advances separated allopathic medicine (which employed conventional means, such as concentrated doses of drugs, to combat disease) from unschooled, self-described healers.

Scientific achievement stimulated social reform. Many progressives believed that poor working conditions, political corruption, and abusive business practices, all of which intensified during America's Industrial Revolution, were, in part, the product of excess competition. In the words of Philander Chase Knox, President Theodore Roosevelt's attorney general, "Uncontrolled competition, like unregulated liberty, is not really free" (as quoted in Morris 2002:88). Government regulation was the antidote. Among the reforms that progressives prescribed were railroad regulation, child labor laws, occupational licensing, and antitrust legislation.

The idea of "regulating" competition in the "public interest," based on scientific principles and standards formulated by experts, linked the ideas of progressives to the interests of physicians. Professionalism was a response to the perceived chaos of the nineteenth century, in which quacks, pretenders, and poorly trained practitioners proliferated for lack of educational standards and government regulation. Medical licensing, which took hold in the late 1800s, was a prime example. On the one hand, politicians gained from having professionals solve societal problems without having to expand the size of government; on the other, professionals furthered their own interests by wielding governmental authority to control competition. "From the perspective of those steeped in America's antistatist culture," historian Brian Balogh observed, "the hierarchy and self-governing mechanisms of the myriad professionalizing organizations were not unlike state and local governments: they dealt with problems without requiring the expansion of the centralized state" (1991:6).

A major tenet common to both progressivism and professionalism was the belief that scientific knowledge was the principal domain of experts. Progressives believed that science was too complex for public consumption, that only experts with advanced education and technical training could grasp its features, and that only experts could apply scientific principles to public problems in an objective and orderly fashion (see Starr 1982:140). These perceptions elevated the status of physicians and distinguished medical work from commercial and business pursuits. Self-regulation was a logical outgrowth of progressive ideas. Because of their advanced knowledge and training, physicians were presumed to be the only ones capable of determining their own technical standards. A unanimous decision of the U.S. Supreme Court, announced in 1888, captured progressives' point of view. "Comparatively few," Justice Stephen Field wrote, could comprehend the

"subtle and mysterious" nature of medical work (*Dent v. State of West Virginia*, 129 U.S. 114, 122–123 [1888]). By 1901, all states had delegated authority to the medical profession to set standards and to police itself (Starr 1982:104).

For medicine, as well as for professions such as law and dentistry, codes of ethics were the principal means of regulating competition in the professional realm. The AMA Code of Medical Ethics, first enacted in 1847, "drew heavily" on the work of Thomas Percival, an English physician who in his 1803 book *Medical Ethics* emphasized professional courtesy and harmony, including the "self-silencing of criticism" (Brennan 1991:32; Berlant 1975:73; Fishbein 1947:36). According to medical ethicist Troyen Brennan, "Many of [Percival's] admonitions were meant to contain intraprofessional strife and to develop self-regulation" (Brennan 1991:32). By way of example, the code banned advertising and solicitation of patients, both widely perceived by physicians as divisive forms of behavior. Rules governing professional conduct, however, did not extend to practitioners outside the profession. Indeed, the code encouraged physicians "to bear emphatic testimony against quackery in all its forms." Homeopaths, eclectics, Christian Scientists, and later osteopaths and chiropractors became targets of physicians and their medical societies.

Enacted in 1890 near the height of the populist movement, the Sherman Act reflected America's suspicion of concentrated power (Hofstadter 1991; Bickel 1983). Progressives, such as Presidents Theodore Roosevelt and Woodrow Wilson, objected to huge combinations, particularly large oil companies and railroad conglomerates owned by John D. Rockefeller, J. P. Morgan, and other business tycoons. Yet, despite the occasional action against a megacorporation, early Sherman Act enforcement efforts more often affected small companies. The simple reason was that cases against small companies were easier to win (McCraw 1984:115). Louis Brandeis, who was Wilson's chief economic advisor from 1912 to 1916, sought to correct this situation. Brandeis believed that small producers were more efficient than large ones. He criticized *Dr. Miles Medical Co. v. John D. Park & Sons Co.* (220 U.S. 373 [1911]), a Supreme Court decision that held that a manufacturer's pricing agreement with several retail outlets constituted price-fixing. Brandeis's central concern was that manufacturers would seek to integrate forward into wholesale and retail trade in order to control prices (McCraw 1984:102). Such "combinations," Brandeis claimed, would destroy rather than enhance competition (McCraw 1984:97; Strum 1993:81).

The philosophy of Brandeis and other progressives underlay passage of

the Federal Trade Commission Act in 1914. Brandeis viewed the act as central to Wilson's New Freedom initiative, which targeted the "great trusts." The Federal Trade Commission, Brandeis proclaimed, should investigate big business and help the Department of Justice enforce compliance with the Sherman Act. It also should provide information to small businesses seeking a level playing field in their battles with large corporations (McCraw 1984:111–112; Mason 1956:403). But the fanfare that accompanied the FTC's inauguration did not last very long. An adverse ruling of the Supreme Court in 1920, coupled with weak appointments to the commission by President Wilson, doomed the agency to second-class status for the next several decades (McCraw 1984:122–128).

Efforts of the AMA to curtail competition were unaffected, for the most part, by the antitrust laws. Indeed, the association revised the code in 1903 to regulate physicians' fees and to prohibit contract practice (Berlant 1975:101, 106). Though the AMA again revised the code in 1912, this time to eliminate "all recommendations for setting fees" (Berlant 1975:102), the change did not undercut the profession's fee-setting capabilities. A major reorganization of the AMA in 1901 had created a policy-making body, the House of Delegates, which comprised representatives from state and local medical societies (Johnson and Jones 1993:6, 42–43). State and local societies could regulate fees just as well as the AMA, if not more effectively. Although some societies faced prosecution under state antitrust laws, the threat was minimal. "Neither the threat of antitrust prosecution nor the constitutional provisions against price-fixing prevented the profession from framing fee schedules in most states," historian James Burrow noted (1977:107). Attorneys general in some states, such as Kansas, pursued price-fixing litigation against physicians, but authorities in other states, Texas and Iowa among them, determined that state laws did not prohibit fee schedules (Burrow 1977:108).

ABRAHAM FLEXNER AND THE REFORM OF MEDICAL EDUCATION

Undoubtedly the most significant achievement of the medical profession during the Progressive Era was reform of medical education. Many physicians believed that efforts to improve standards through rigorous training and a comprehensive, science-based curriculum would end "inordinate competition and all the evils of an unstable market" (Rosen 1983:64). By making it harder for individuals to enter the profession, medical schools would produce fewer doctors, and those doctors that schools did produce would be more highly trained and competent than in the past.

To be sure, Abraham Flexner's "muckraking" report of 1910, prepared for the Carnegie Foundation for the Advancement of Technology, advanced medicine's cause. But Flexner was not the first to assess the profession's educational status. The AMA had initiated inspections of medical schools before 1910 through its Council on Medical Education. The council conducted three tours of inspection, the first two between 1906 and 1910. Based on a rating scale devised to assess such things as the quality of clinical instruction, curriculum, admission requirements, and facilities, the council targeted for closure all schools that fell below a 50 percent rating (the equivalent of an F; Dodson 1919). Morris Fishbein, the powerful editor of the *Journal of the American Medical Association (JAMA)*, reported the results of the council's inspections: "There were 160 medical schools; 82 had been rated above 70, 46 between 50 and 70 and 32 below 50. The Council condemned medical schools conducted solely for profit, night schools, schools designed to prepare students to pass state board examinations, quiz courses and many others" (Fishbein 1947:250). The AMA's early efforts were productive. According to Fishbein (p. 268), "The Council on Medical Education reported a reduction in medical colleges from 166 in 1904 to 129 in 1911."

Flexner, who began his inspection tour of medical schools in December 1908, "capitalized" on the work of the Council on Medical Education (Rosen 1983:63). Lacking formal training in medicine, Flexner received advice from leading physicians and faculty of the Johns Hopkins School of Medicine. Indeed, the Hopkins model, which stressed scientific research and clinical instruction, became the benchmark for Flexner's evaluation.

Flexner called upon medical schools to tighten their admission standards so that candidates "would begin their professional training with adequate basic preparation, particularly in science" (Rosen 1983:64). Medical schools, Flexner said, should also require hospital affiliation to assure "effective teaching of clinical medicine" (Rosen 1983:64). Proprietary schools and those "poorly financed and equipped" failed the Hopkins test (Rosen 1983:64). According to James Johnson and Walter Jones, Flexner's report "was a classic case of research gaining influence through release at the right time, into the right hands. States responded to the report's scandalous findings with a wave of regulation that implemented the unified education model that the AMA and others advocated" (1993:6).

Flexner's report accelerated a trend in school closures that had begun with the reinstitution of state licensure and the work of the Council on Medical Education. State licensing boards, under the control of professional associations, refused to license graduates from medical schools that the boards had not approved. In order to make the "approved" list, schools had

to satisfy the AMA's standards, an expensive undertaking that forced proprietary institutions to upgrade their facilities and to extend the period of time for training prospective physicians. Because proprietary schools depended on tuition and fees to finance their operations, incoming students had to offset these new expenses. Many students lacked the means and the additional time required for medical training. Enrollments decreased, and the weaker schools closed (Starr 1982:118–119). In 1910, the year Flexner's report came out, there were 131 schools; twelve years later, there were only 81 schools of medicine (Rosen 1983:65).

Progressive reform of medical education gave professional associations the ability and the opportunity to restrict the supply of physicians. The Council on Medical Education became, in effect, an arm of the state used for determining which schools made the "approved" list. "Even though no legislative body ever set up the Federation of State Medical Boards or the Council on Medical Education, their decisions came to have the force of law," Paul Starr suggested (1982:121). The creation of a private entity to perform a public function had important implications. Once formed, such an entity could monitor and control the flow of information between the public and the private sectors.

AMA control of medical school enrollments spilled over to graduate medical education. Though professional organizations comprised of medical specialists developed separately from the AMA in the 1920s, by the late 1930s, the AMA had achieved a prominent role in specialty education, including internship and residency training. Again, the Council on Medical Education became the central mechanism for approval of specialty boards, their standards, and their practices (Stevens 1971:213–214). In addition, the council, almost by default, assumed responsibility for the inspection and recognition of hospitals for internships and residencies. To be sure, the AMA wanted it this way, but no other suitors existed. Medical schools lacked the required resources, and the Advisory Board for Medical Specialties formed in 1933 was, as its name suggested, "advisory" in nature (Stevens 1971:212–215, 260–263).

CONTRACT PRACTICE AND THE AMA'S TEN PRINCIPLES

Contract practice originated in the railroad, mining, and logging industries of the late nineteenth century. Physicians provided medical services to groups of patients for a fixed fee, unlike the traditional fee-for-service model. Industrial corporations, indemnity companies, benevolent and fraternal orders, farm cooperatives, and hospital associations were among the

entities that engaged physicians at discount prices. Competition among physicians was so intense and incomes so low that many doctors readily accepted the discount rates (U.S. Congress, Senate, 1974:1598 [Treatise by L. S. Helland, Re: Structure of Health Care Delivery]; Burrow 1977:15, 119–132). Contract practice touched any area of the country where low-income farm workers and industrial laborers congregated.

The medical profession opposed contract practice and its counterpart, the corporate practice of medicine. Contract practice concerned physicians who sold their services to organizations or entities for a fixed fee; “corporate practice of medicine” referred to those organizations that marketed physicians’ services. There are at least three reasons why medicine opposed contract and corporate practice: first, independent practitioners viewed most organizations that provided health care, such as dispensaries, clinics, or hospital associations, as potential competitors; second, physicians feared that if such organizations gained a foothold, they would dictate the terms of payment; third, practitioners believed that corporate intermediaries would interfere with their clinical autonomy (Starr 1982:25, 215–218; Rosen 1983:97–108). While the profession could invoke medical ethics to prohibit doctors from undertaking contract practice, it needed states to enact laws to prevent companies from pursuing the corporate practice of medicine.

Resistance to contract practice hardened during the Progressive and New Deal eras. In 1913, the Judicial Council “recommended definite action toward the elimination of the abuse of so-called lodge practice” (Fishbein 1947:277). For a brief period, contract practice diminished as educational reforms that reduced physician supply lessened competition (Burrow 1977:119–132). But reliance on contract practice as a source of income increased again in the late 1920s as economic conditions worsened with the onset of the Great Depression (U.S. Congress, Senate, 1974:1599 [Treatise by L. S. Helland, Re: Structure of Health Care Delivery]; Rosen 1983:70). Several prepaid health plans associated with hospitals or clinics emerged, including ones attached to Baylor University Hospital in Dallas and the Ross-Loos and Palo Alto Clinics in California (Kessel 1958:40–41; Weller 1984:1361). According to Charles Weller, there were at least fifty-eight plans at the height of the movement in 1933, representing “an exciting diversity of innovative, competitive, and pluralistic market free choice plans” (1984:1361, 1363).

Physician Michael Shadid, a Syrian immigrant, established the first cooperative hospital in the United States in Elk City, Oklahoma, in 1929 (Shadid 1939:15). Combining principles of group practice with those of periodic payment, consumer control, and preventive medicine, Shadid sought to

improve medical delivery in rural communities during hard times. "In the large cities," Shadid wrote, "the doctor can send his patients to one of the many specialists available, but in the villages and small towns, of which our country is in the main composed, this is impossible" (1939:108-109). Improved access to quality care motivated Shadid's design. "I looked into the history of the many privately owned clinics that had been established. Most of them had gone out of existence. There are a few outstanding exceptions, such as the Mayo Clinic in Rochester, Minnesota, which is first-rate and highly successful. But they are so expensive that only the rich can afford them. And there lay the chief flaw in the clinic plan, as far as I was concerned. Operated on a profit basis, the rates are beyond the reach of all but a small percentage of the population" (Shadid 1939:110-111).

Shadid's attempts to create a clinic in Elk City encountered professional resistance (Shadid 1939:254). Fearing "a reduction in their individual incomes," local doctors took steps to revoke Shadid's license, to oust him from the local medical society, to cancel his medical malpractice insurance, to undercut the price of his medical services, to interfere in his recruiting of out-of-state physicians, and to form competing (sham) cooperatives (Shadid 1939:115, 124, 133-142, 152-157). Even the AMA entered the fray. AMA officials successfully pressured the federal government to end federal aid to low-income farm workers seeking care at Shadid's hospital on the grounds that the hospital did not operate "in accordance with the Principles of Medical Ethics" (Shadid 1939:161-163).

Intense opposition to contract practice reflected a change in the AMA's leadership and philosophy once the association secured political power and authority. In the early 1900s, the AMA "tended to favor physicians prominent in education, research, or clinical practice for the presidency [of the AMA]," but during the 1930s, "politically-oriented conservatives" assumed control (Campion 1984:102-103). "An increasingly wealthy part of the medical Establishment . . . moved to the right politically," Johnson and Jones observed (1993:64). Urban specialists came to dominate the association's councils and committees (Garceau 1941). Michael Shadid lamented the transformation. He wrote:

Like so many political parties, [the AMA] originated as a forward-looking association that fought for much-needed improvements, only to degenerate into a bureaucracy upholding the status quo. Many years ago the A.M.A. forced out of existence the "diploma mills" and raised standards of medical schools throughout the country; it brought about an increase in the amount of training required of physicians; it combated the spread of quacks, false cures, and patent medicines making misleading claims. It

established a code of ethics that was originally drawn up for the protection of the public against unscrupulous doctors but which now is twisted so as to serve for the protection of unscrupulous physicians against the public. (Shadid 1939:203)

Morris Fishbein led medicine's conservative vanguard from 1924 until his ouster from the AMA in 1949. The association did not collect dues from its members during Fishbein's tenure, making advertising and subscription sales of *JAMA*, which Fishbein edited, the primary source of revenue. Consequently, the AMA was "financially dependent on Fishbein . . . to a great degree" (Campion 1984:114). Association bylaws provided that Fishbein could attend meetings of the Board of Trustees, "and from 1924 on, for a quarter of a century [he] did so," becoming, in Frank Campion's words, "an imposing figure, the almost permanent nature of his presence there adding weight to the vigorously argued opinions he had to offer" (Campion 1984:114).

Fishbein railed against contract practice and "socialized medicine" in the boardroom and in numerous editorials. Perhaps his most famous (if not infamous) editorial, published in 1932, attacked the recommendations of the Committee on the Costs of Medical Care (CCMC). The CCMC, composed of several respected and influential members of the health care community, produced a series of reports between 1927 and 1932 that detailed certain deficiencies in the delivery and financing of health care. The CCMC urged reform. Among the reforms the CCMC recommended was prepaid group practice (Starr 1982:261–266; Weller 1984:1361; Brennan 1991:41).

Despite the "prestigious" composition of the committee, Fishbein vigorously and unceremoniously attacked the committee's recommendations (Campion 1984:117). An editorial he wrote for *JAMA* compared group practice to "medical care by . . . medical soviets" and "public health officialdom" to "socialism and communism" (Fishbein 1932:1950–1952). From Fishbein's perspective, prepaid group practice and government-run medicine were virtually the same. Though Fishbein's rhetoric seemed extreme, he had the support of medicine's rank and file (see Fox 1986). Indeed, a strong cohort of physicians on the CCMC, mostly those in private practice, opposed the findings of the majority. These physicians prepared a minority report. "The evils of contract practice are widespread and pernicious," they wrote. "[We] recommend that the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed" (Fishbein 1947:398).

In 1934, the Bureau of Medical Economics of the AMA, at Fishbein's urging, prepared a study on contract practice, group practice, and "sickness insur-

ance" (Fishbein 1947:1066–1067). The report contained ten principles for the formation of private health plans. These ten principles were as follows:

- *First:* All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control.
- *Second:* No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical services must be borne by the profession.
- *Third:* Patients must have absolute freedom to choose a legally qualified doctor of medicine who will serve them from among all those qualified to practice and who are willing to give service.
- *Fourth:* The method of giving service must retain a permanent, confidential relation between the patient and the family physician. This relation must be the fundamental and dominating feature of any system.
- *Fifth:* All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical service should be considered separately. These institutions are but expansions of the equipment of the physician. He is the only one whom the laws of all nations recognize as competent to use them in the delivery of service. The medical profession alone can determine the adequacy and character of such institutions. The value depends on their operation according to medical standards.
- *Sixth:* However the cost of medical service may be distributed, the immediate cost should be borne by the patient if able to pay at the time the service is rendered.
- *Seventh:* Medical service must have no connection with any cash benefits.
- *Eighth:* Any form of medical service should include within its scope all legally qualified doctors of medicine of the locality covered by its operation who wish to give service under the conditions established.
- *Ninth:* Systems for the relief of low income classes should be limited strictly to those below the comfort level standard of incomes.
- *Tenth:* There should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession. (from Rayack 1967:164–165)

The AMA House of Delegates approved the ten principles in full. Boiled down, the ten principles fell into three main categories, or core beliefs, of the medical profession: *self-regulation*, *clinical autonomy*, and *free choice of physician*. Self-regulation underlay principles 1, 5, and 10. Clinical autonomy conflated principles 2, 4, 6, and 7. Free choice of physician underscored

principles 3, 8, and 9. Once issued, the ten principles became, for the next several decades, the template for the delivery and finance of health care in the United States.

Professional associations were quite serious about enforcing the ten principles, and they used several means to gain compliance with their terms. To bolster enforcement efforts, the House of Delegates passed the Mundt Resolution in 1934. Mundt tied medical staff membership in the AMA to formal approval of hospitals for internship training (Fishbein 1947:408). Recalcitrant physicians now faced a variety of disciplinary sanctions, including license revocation, loss of hospital privileges, and expulsion from state and local medical societies. By way of example, professional societies targeted physicians affiliated with the Dallas Medical and Surgical Clinic and International Harvester in Wisconsin (Fishbein 1947:408–409; Weller 1984:1367). Medical societies also led boycotts of hospital associations, group clinics, and nonconforming insurers, that is, any entity that failed to operate as they decreed.

These tactics raised questions about the extent of medicine's powers. How far could medical societies go to gain conformance with independent, fee-for-service practice? Did medicine have *carte blanche* to regulate the health care industry? Did the antitrust laws even apply? In 1938, the Department of Justice served notice that the AMA had gone too far.

THURMAN ARNOLD AND THE GROUP HEALTH CASE

The events leading to the indictment of the AMA by the Department of Justice in 1938 for conspiring to “impair or destroy” the business of the Group Health Association, a Washington, D.C., cooperative formed to provide medical services to certain government employees, revealed as much about the “ambiguous” state of antitrust policy as they did about the growing power of the medical profession (Gressley 1977:40). Harsh economic times at home and abroad in the 1920s and 1930s raised questions about the efficacy of competition, which, many complained, harmed small producers and brought about large fluctuations in the economy.

International cartels or combinations of independent enterprises designed to limit competition gained traction from policy makers seeking to overcome economic disruptions. Advocates claimed that cooperation among rivals had the potential to stabilize prices and prevent overproduction. The League of Nations endorsed cartels, as did many European countries, such as Great Britain, in order to “rationalize” the production of goods and services, particularly in “depressed industries like textiles and steel” (Wells 2002:11). Oppo-

sition to cartels was strongest in the United States, but the Great Depression altered beliefs about industry collusion and government regulation. Recognizing the need for American companies to compete on more favorable terms in export markets, Congress passed the Webb-Pomerene Act in 1918. Webb-Pomerene exempted U.S. firms from the antitrust laws so long as they confined their operations to foreign markets (Wells 2002:17, 33).

During the 1920s, the "associationalist" movement gained popularity among policy makers in the United States (Kovacic 1982:607). Advocates of associationalism believed that self-regulation and cooperation between business and government did more to stimulate the economy than market competition. Associationalist policies reached their height in the early years of the New Deal. The short-lived National Industrial Recovery Act (NIRA), which Congress passed in 1933 and the Supreme Court struck down in 1935, was the leading example of these policies. NIRA suspended the anti-trust laws and called upon government, business, and labor leaders to draft "codes of conduct" for entire industries. "Desperate to halt the downward spiral of the economy," historian Wyatt Wells observed, "Americans seemed willing to abandon the antitrust tradition" (2002:36).

AMA leaders, such as Morris Fishbein, grasped the significance of New Deal economic policy. A 1935 publication of the AMA contained the following endorsement: "Recent national legislation [NIRA] proposes to extend the functions of such trade associations much further and to give them a very extensive control over the various industries and to hold them responsible for the amount of production, for prices and for the competitive relations of their members. These are functions closely analogous to those long conducted by professional associations and would seem to indicate that industry is finding it desirable to follow professional models rather than the reverse" (as quoted in Weller 1984:1355 n. 23). Fishbein and other medical leaders apparently had concluded that collusion among physicians through their medical societies was permissible and that government policy promoted the practice.

As the economy continued to sputter, however, associationalism and cartelization lost support. Following another steep recession in 1937, members of Congress and the academic community spoke out against industrial concentration, causing Roosevelt to reverse course (Gressley 1977:42). President Roosevelt, Wells wrote, "embraced antitrust out of desperation" (2002:38). In 1938, Roosevelt appointed Thurman Arnold, an opponent of cartels, to head the Antitrust Division of the Department of Justice. Under Arnold's direction, the Department of Justice took action against the petro-

leum, chemical, and other large industries for their collusive practices. Representing an even further break from the past, Arnold also targeted the AMA, which in 1938 comprised 110,000 out of 145,000 American physicians.

Thurman Arnold's antitrust philosophy reflected his Western roots and his teaching experience at Yale University, where the "legal realist" school was in vogue. Although distrustful of big business, Arnold was "less doctrinaire than Brandeis" (Wells 2002:41). "The test is efficiency and service—not size," Arnold wrote (as quoted in Wells 2002:41). Despite some grounding in law and economics, Arnold was not an economic practitioner. According to his biographer, Gene Gressley, Arnold "had an innate skepticism of 'preachers' with manufactured economic panaceas" (1977:43). A litigator, not a theoretician, Arnold fashioned "a pliable policy molded to the necessities of the individual prosecutions" (Gressley 1977:47).

Notwithstanding Arnold's skepticism of economic theory, his writings augured the chief tenets of what would be called the Chicago school—consumer welfare and economic efficiency. "The idea of antitrust laws is to create a situation in which competition compels the passing on to the consumers the savings of mass distribution and production," Arnold wrote (as quoted in Gressley 1977:54). "The only purpose [of the antitrust laws]," he noted, "is to see that corporate growth results from efficiency—not the elimination of competition by aggression or merger" (p. 463). In a letter penned in 1966, Arnold asserted that antitrust enforcement during the Roosevelt administration marked a turning point in the trend "toward a European cartel system" (as quoted in Gressley 1977:464). "Had Roosevelt not decided to attack such combinations," Arnold claimed, "we would have ended up in a few years with a legally approved cartel system" (pp. 462–463).

Arnold's case against the AMA involved a conspiracy to induce physicians and hospitals to boycott Group Health, the aforementioned Washington, D.C., cooperative. The alleged co-conspirators threatened to expel (and in a couple instances did expel) from their local medical societies physicians who either joined the medical staff of Group Health or consulted with staff physicians. They circulated "white lists" of approved organizations, groups, and individuals, omitting the name of Group Health. And they invoked the Mundt Resolution to intimidate Washington hospitals that admitted Group Health doctors to their medical staffs. Coercion of hospitals, according to the Department of Justice, constituted "the most serious interference with the activities of Group Health. Conceivably, the association might have functioned without medical society doctors and without the benefit of their consultations. But under present-day conditions it could not offer provisions for

health services of value, without [access to] hospitals" (Brief for the United States 1939:88).*

True to their personalities, Fishbein and Arnold emerged as the lead combatants in the Group Health case. Arnold struck first, naming Fishbein a co-conspirator along with several other individuals and professional entities, including the AMA and the District of Columbia Medical Society. According to Fishbein, Arnold "delicately timed" the indictments on a Sunday afternoon "for Monday morning newspapers" (Fishbein 1947:534). In truth, Arnold had released two previous statements concerning the matter and, as Fishbein admitted, had given the AMA the "opportunity to avoid trial by agreeing to consent decrees which would assure the cooperation of the [AMA] in the operation of cooperative clinics" (1947:534). But Fishbein was not interested. The *JAMA* editor responded to Arnold's indictment in his inimitable fashion: "The statement by the assistant attorney general is in accord with the point of view which he has held for some time in relationship to our government," Fishbein wrote (1947:534). "Apparently it remains to be determined whether or not the federal administration can use the laws and the courts to mold the people of the United States to its beliefs in every phase of life and living" (1947:534).

Opinions, not surprisingly, differed. Several newspapers criticized Arnold for attacking the medical profession. The *New York Daily Mirror* complained that "Arnold's system is a brutal combination of the Star Chamber and Nazi bureaucracy." "The doctors of America should unite," the newspaper said, "in this fight against a system which jeopardizes the liberties of every citizen" (as quoted in Fishbein 1947:537). H. L. Mencken, the acerbic columnist for the *Baltimore Sun*, was equally vociferous. According to Arnold, Mencken was "very much annoyed with me for my prosecution of the [AMA] . . . he thought that Dr. Fishbein was a very great man indeed, and in my investigation of the AMA files during the prosecution I found a note from Mencken urging Fishbein not to be intimidated by these New Deal 'goons'" (as quoted in Gressley 1977:453–454). Years later, Arnold retorted: "It has been my experience that any group, whether from labor or industry or the profession, which gets itself in a position where it thinks it has special privileges will fight for them with complete intolerance and that John L. Lewis and Dr. Fishbein are brothers under the same skin" (as quoted in Gressley 1977:383).

Although the facts favored Arnold, a legal issue emerged that jeopardized the prosecution's case. Section 1 of the Sherman Act "prohibit[ed] contracts,

*Harold C. Havighurst, Clark Havighurst's father, was a special assistant to Thurman Arnold in the Group Health case (see Brief for the United States 1939:88).

combinations and conspiracies that unreasonably restrain[ed] *trade*" (emphasis added). Did the practice of medicine constitute a trade for purposes of the Sherman Act? Relying on Supreme Court precedent, the U.S. district court for the District of Columbia held that the word "trade" excluded the "learned professions" (*United States v. American Medical Ass'n*, 28 F.Supp. 752, 755 [D.D.C. 1939]). Exuberant, Fishbein wrote: "The [court's] opinion . . . lends encouragement and is an inspiration to continuous effort in behalf of a free profession. The medical profession of this country will not be coerced, threatened, abused, or otherwise maltreated, and it will fight to the finish when its high traditions demand a righteous resistance" (1947:541).

But Fishbein's exuberance was short-lived. The United States Court of Appeals for the District of Columbia reversed, holding that the word "trade" embraced medical practice as well as ordinary commercial activity (*United States v. American Medical Ass'n*, 110 F.2d 703, 711 [D.C. Cir. 1940]). Having ruled against the AMA, the appeals court remanded the case to the district court for trial. Following a lengthy hearing, a jury acquitted the individual defendants but held against the AMA and the District of Columbia Medical Society. Thereafter, the trial judge fined the AMA and the medical society in the amounts of \$2500 and \$1500, respectively.

Despite the meager fines, the AMA filed a petition for a writ of certiorari to the U.S. Supreme Court. Although the Court agreed to hear the case, it failed to decide the "trade" issue (*American Medical Ass'n v. United States*, 317 U.S. 519 [1943]). In an opinion by Justice Owen Roberts, the Court reasoned that the government only had to show that defendants had conspired to restrain the business of Group Health, "a membership corporation engaged in business or trade." It was unnecessary, the Court determined, to decide "the question whether a physician's practice of his profession constitutes trade under [Sherman]" (*American Medical Ass'n*, 317 U.S. at 528). Having skirted the "trade" issue, the Court upheld the AMA's conviction.

Although this ruling was a defeat for the AMA, the reach of the Group Health case was limited. Because the Court did not decide whether "trade" and "profession" were coterminous, the de facto "learned professions" exemption was still viable. Moreover, future prosecutions, if they were outside Washington, D.C., would have to satisfy the commerce clause of the U.S. Constitution. Because the commerce clause restricted federal authority to commerce "among the several states," antitrust enforcers would have to show that any conspiracy to restrain trade would have a "substantial effect" on interstate commerce. This was a difficult undertaking. Most members of the legal community considered the practice of medicine to be wholly intrastate.

Other barriers to prosecution existed as well. The most important of these was the doctrine of state-action immunity that the Supreme Court announced in 1943, the same year it decided the Group Health case. In *Parker v. Brown*, the Court held that the Sherman Act applied to "individual and not state action." The Court reasoned that "in a dual system of government in which . . . the states are sovereign," state regulation trumped federal antitrust policy (*Parker*, 317 U.S. at 351). By creating an exemption for state-supported activity, the Court encouraged medical societies to lobby state legislatures for antitrust protection. Various state enactments that barred the formation of lay-controlled plans or required all plans to provide free choice of physician were protected from the reach of the Sherman Act. The "corporate practice of medicine doctrine," a product of state court rulings, also fell within *Parker's* zone of protection. Based on flimsy analysis, the corporate practice of medicine doctrine prohibited corporations from retaining physicians to treat patients on a prepaid basis. Because corporations could not obtain a license to practice medicine, judges reasoned, they also could not employ or in certain circumstances engage licensed physicians to do it for them (see *People v. United Medical Services, Inc.*, 200 N.E. 157 [Ill. 1936]; *Parker v. Board of Dental Examiners*, 14 P.2d 67 [Cal. 1932]; see also Chase-Lubitz 1987:464–467). Rather than enhance prepaid group practice, as the Group Health case signaled, the Court's ruling in *Parker* undercut the formation and development of alternative delivery systems.

Nonetheless, the decision in the Group Health case had more than symbolic effect. The case was the first attempt by the Department of Justice to apply the antitrust laws to the medical profession. Several prepayment plans, including Kaiser Permanente, the Health Insurance Plan of New York, and Group Health Cooperative of Puget Sound, emerged in the 1940s, at or near the end of the Group Health case. Kaiser and other plans succeeded largely because some state courts (mostly on the West Coast) upheld lay-controlled plans (Starr 1982:324). In addition, many of the tactics that professional associations had employed in the Group Health case became suspect, forcing societies to adopt new strategies to eliminate competition. One such strategy, employed by medical societies against a prepayment plan located in Oregon, piqued the interest of the Department of Justice in the late 1940s.

THE OSMS CASE

Lay-controlled prepayment plans were most prominent in states on the West Coast, such as Oregon, where several "hospital associations" provided

health care for a fixed price to workers in the lumber, railroad, and mining industries (Goldberg and Greenberg 1977:50). Oregon's state legislature fostered the hospital-association movement when it passed a law that expressly permitted the corporate practice of medicine. Hospital associations flourished in Oregon, and by 1935, they financed 60 percent of all insurance disbursements (Goldberg and Greenberg 1977:51).

The hospital associations aggressively sought to contain costs, using many of the tactics later employed by managed care, such as preauthorization, utilization review, and fixed payments for certain medical procedures. State and local medical societies in Oregon objected to these cost-containment measures, declared them "unethical," and threatened expulsion and disciplinary action against physicians who cooperated with the hospital associations. Unlike the situation in the Group Health case, however, these tactics proved unsuccessful. In 1941, soon after the federal circuit court held against the AMA in the Group Health case, medical societies in Oregon formed their own prepaid health plan, known as the Oregon Physicians Service, or OPS.

The "prospect of wide enrollment, of assured payment for services, of noninterference in clinical decisions, and of increased professional solidarity" attracted physicians to OPS (Goldberg and Greenberg 1977:58). By 1943, OPS dominated the market for health insurance, achieving a 60 percent share. But Oregon's medical societies were not content to let the matter rest. Employing some of their former tactics, the medical societies made noncooperation with the hospital associations a condition of joining OPS. They also discouraged physicians from "taking tickets" from patients who were members of hospital associations. Direct reimbursement of physicians through their patients' "tickets" was the primary mechanism that hospital associations used to curtail costs. Combined with the large number of physicians who joined OPS (85 percent of all licensed physicians in the first year), such tactics proved fatal to the hospital associations. Those few hospital associations that survived agreed to abandon their cost-containment efforts, including utilization and fee review. In 1946, OPS became part of an emerging network of Blue Shield plans (Goldberg and Greenberg 1977:58-62).

Seven years after the founding of OPS, the Department of Justice brought action against the Oregon State Medical Society, several local societies, and certain individual physicians for injunctive relief. Specifically, the Department of Justice claimed that defendants had attempted to monopolize prepaid medical care. Following a lengthy trial, the federal district judge who heard the case held that the Department failed to prove its case against the physicians and their medical societies (*United States v. Oregon State*

Medical Society, 95 F.Supp. 103 [D. Or. 1950] [hereafter *OSMS*]). He determined that OPS was “not a conspiracy but, rather, an entirely legal and legitimate effort by the profession to meet the demands of the times for broadened medical and hospital service” (*OSMS*, 95 F.Supp. at 105).

On appeal, the U.S. Supreme Court, in an opinion by Justice Robert Jackson, affirmed the lower court’s decision (*United States v. Oregon State Medical Society*, 343 U.S. 326, 330 [1952]). Jackson agreed with the district judge that the evidence against the defendants was deficient. That should have ended the matter. But Jackson, in a statement unnecessary to the Court’s holding (known as *dictum*), signaled that the antitrust laws weakly applied to the “ethical standards” of the medical profession. Jackson declared: “We might observe in passing, however, that there are ethical considerations where the historic direct relationship between patient and physician is involved which are quite different than the usual considerations prevailing in ordinary commercial matters. This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession” (*OSMS*, 343 U.S. at 336). Justice Jackson’s famous dictum, oft-repeated in subsequent cases, seemed difficult to reconcile with the Court’s ruling, nine years earlier, in the Group Health case. What, if anything, had changed during the intervening years to explain the Court’s position? Did Jackson, who failed to take part in the Group Health case, spurn prepaid group practice?

The context for the case, set against the Korean War and anticommunist fervor, likely influenced the Court’s disposition. Investigations of communist sympathizers, led by Senator Joseph McCarthy, dominated the headlines, as did the espionage trial of Julius and Ethel Rosenberg. Antisocialist rhetoric clouded the debate over access to health care. In 1947, Marjorie Shearon, a former federal employee, accused certain individuals at the Federal Security Agency of conspiring to nationalize health insurance (Campion 1984:160). And in 1949, President Truman placed compulsory health insurance on the national agenda. Vehemently opposed to Truman’s initiative, the AMA engaged Whitaker and Baker, a public relations firm, to stigmatize the president’s plan. “The doctors of this country are in the front lines today of a basic struggle between socialism and private initiative,” Whitaker and Baker declared (Campion 1984:159).

The opinion of the federal district judge in *OSMS* captured and highlighted the debate over socialized medicine. No “American court [should] hold that . . . organized medicine must remain a sitting duck while socialism overwhelms it,” the judge asserted (*OSMS*, 95 F.Supp. at 113). “Constitutional Democracy is not a one-way road,” he continued.

Those who believe in things as they are, or who seek to retain them in modified form may oppose radical change, without becoming subject to the criminal laws. That certainly includes vitally interested parties whose way of living itself, is threatened. . . . Social forces, acting through the Government may impinge on me, but I can oppose them with all my might. That is one of the issues in this case. What is the purpose of the doctors in organizing the Oregon Physicians' Service? Was it to obtain a monopoly in the prepaid medical field, or was it to save themselves and their profession from threatened socialization? I hold it was the latter, and that nothing in the anti-trust laws deprives them of the right to fight to defend their independent professional status. (*OSMS*, 95 F.Supp. at 109)

Though attorneys at the Justice Department rightly claimed that judicial bias had affected the outcome of the case, the Supreme Court overlooked the trial judge's "soliloquies on socialized medicine" (*OSMS*, 343 U.S. at 332). When it came to the perquisites of professional sovereignty, neither the medical profession nor the federal courts sought to distinguish between governmental and commercial activities.

THE GOLDEN AGE OF MEDICINE

Some scholars have labeled the period from about 1945 to 1965 the golden age of medicine (see Burnham 1982; Freidson 1973). This was a period, sociologist Eliot Freidson professed, when medicine "was at a historically unprecedented peak of prestige, prosperity, and political and cultural influence—perhaps as autonomous as a profession could be" (1973:384). As this chapter has shown, medicine's rise from "virtual political impotence" to "monopolistic control of medical practice" hinged upon scientific advances, organizational changes, and educational reforms that unified the profession and undermined its competition (Burrow 1977:12; Rosen 1983:66). The ideas of progressive reformers—in particular, the notion that experts, as proxies of government, could regulate competition in the public interest—groomed medicine's path. By 1920, physicians had gained exclusive authority over the terms, conditions, and content of medical work. The first journal of a state medical society appeared in 1896; by 1917, twenty-seven state societies had their own journals (Burrow 1977:168). There were 166 medical schools in 1904; by 1922, there were only 81. Before 1900, "fierce conflicts raged" between allopathic physicians and sectarians; by the end of the Progressive Era, such conflicts "[had] been all but forgotten" (Burrow 1977:68).

During the 1930s, the philosophy that underlay professionalism—the

pursuit of knowledge and a higher social calling—succumbed to the political and economic interests of physicians and their professional associations. The elevation to power of Morris Fishbein and other opponents of contract practice and government-sponsored health care transformed the AMA from an organization that promoted education and research to one that exploited professional authority. Though medical educators and some prominent specialists expressed disappointment and frustration with the profession's confrontational course, most private practitioners, who dominated the AMA, were unified in their goals and purposes.

Having achieved domination over health care delivery, the medical profession opposed any changes to the status quo. Despite the growing needs of a destitute and expanding population in the Great Depression, medicine rejected contract practice and any other proposal to expand health care delivery, whether government or market based. The only exceptions were indemnity insurance, which satisfied the AMA's ten principles, and Blue Shield plans, which doctors controlled. Commercial indemnity insurers upheld professional autonomy—insurers reimbursed patients, not physicians. In addition, indemnity insurers adhered to free choice of physician—patients could choose any doctor they wanted, generalist or specialist; the insurer was not involved. Although Blue Shield plans, which appeared in the 1940s, violated professional autonomy because such plans paid physicians directly for their work, the AMA granted an exception, albeit reluctantly, since “doctors ran the plan” (Starr 1982:306). Physicians, however, had to satisfy several conditions in order to receive payments from Blue Shield: they could not participate in competing plans; they could not engage in contract practice; and they had to adhere to fee schedules that Blue Shield and the professional societies agreed upon (U.S. Congress, Senate, 1974:1580 [Statement of John W. Riley]).

The antitrust laws, as interpreted and applied throughout the Progressive and New Deal eras, did little to discourage the anticompetitive practices of physicians and their professional associations. Progressive ideas bolstered medicine's claim that those who drafted the Sherman Act did not countenance the learned professions. New Deal reformers, moreover, advanced the notion that collaboration among independent producers, both large and small, was better for the economy than outright competition. Still, there were certain boundaries that medical societies, in the pursuit of power and hegemony, exceeded at their peril. When medical societies crossed these boundaries, as in the Group Health and OSMS cases, they had to pull back, but not very far.

The AMA's scant revisions to its Code of Medical Ethics in the years fol-

lowing the Group Health and OSMS cases indicated that the profession did not fear the antitrust authorities. Code revisions in 1949 moderated the restriction on contract practice (it “was no longer unethical per se”), yet reinstated past limitations on associating with unscientific practitioners. But these changes were superficial at best. A physician still “could not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit[ted] exploitation of the services of the physician for the financial profit of the agency concerned” (AMA Code of Medical Ethics 1949). To sociologist Jeffrey Berlant, the new language actually enhanced the ability of the AMA “to oppose organizational arrangements it did not favor, without making explicit its criteria for exploitation” (Berlant 1975:108).

In 1957, the AMA again revised the code. Though the revisions appeared to be extensive, the changes had negligible effect on the profession’s anti-competitive activities. To a significant extent, the provisions of the 1949 code remained intact. Soon after its issuance, the Judicial Council even announced that “the 1957 edition . . . was not intended to and d[id] not abrogate any ethical principle expressed in [the 1949] edition” (AMA, *Opinions and Reports* 1969:v).

The failure of federal courts and agencies to stop anticompetitive practices of professional societies was not because the antitrust laws were deficient in their scope and purpose. Rather, the reticence of courts and agencies stemmed from a set of ideas that looked upon professional behavior as a model for others, including government and industry. In addition, the pre-capitalist configuration of health care delivery (independent practitioners and stand-alone hospitals) made it difficult to prove that a particular restraint of trade had a “substantial effect” on interstate commerce. Under the circumstances, medicine’s dominance of the health care industry remained secure well into the 1960s.