A Sacred Trust

RICHARD HARRIS

PENGUIN BOOKS INC

Penguin Books, Inc., 7110 Ambassador Road,
Baltimore, Maryland 21207, U.S.A.
Penguin Books Ltd, Harmondsworth,
Middlesex, England
Penguin Books Australia Ltd, Ringwood,
Victoria, Australia

First published by The New American Library, Inc. 1966
Published in Pelican Books 1969
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Most of the contents of this book
appeared originally in *The New Yorker*,
in somewhat different form.

Set in Linotype Primer
Printed in the United States of America
by Universal Lithographers, Inc.

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SINCE the politician's first principle is to avoid taking on any more organized opposition than he has to, the first principle for those who want to influence politicians is to organize. With this elementary rule in mind, millions of people in the United States have banded together in some two thousand organizations and have sent their men off to Washington—lobbyists who represent everything from the National Association of Manufacturers and the American Federation of Labor-Congress of Industrial Organizations to the Camping Club of America and the Southwestern Peanut Shellers Association. For every member of Congress there are ten lobbyists, and the most modest estimates of what they spend in the course of working for or against specific pieces of legislation that interest their employers run to more than a billion dollars a year. In a sense, the Washington representatives of special-interest groups constitute a third house of Congress, since half of all the measures introduced in the Senate and the House of Representatives were originally written in their offices.

Far and away the most resolute contingent of lobbyists in recent years has been that of the American Medical Association. When the A.M.A. was founded, in 1847, its purpose, according to its constitution, was "to promote the science and art of medicine and the betterment of public health." Up until the time of the First World War, the Association restricted its activities to improving medical education, setting standards of practice, and policing quacks. Since that time, however, it has devoted more and more of its energies and considerable resources to persuading anyone who would listen, particularly lawmakers, that the only way to bring about the betterment of

public health was to keep it in private hands. The dread of outside interference has led the A.M.A. to oppose even the mildest and most constructive official and semi-official intrusions, including compulsory inoculation against diphtheria and compulsory vaccination against smallpox, the mandatory reporting of tuberculosis cases to public-health agencies, the establishment of public venereal-disease clinics and of Red Cross blood banks, federal grants for medical-school construction and medical-student loans, Blue Cross and other private health-insurance programs, government subsidies to reduce maternal and infant deaths, and free centers for cancer diagnosis. The A.M.A.'s arguments against these proposals have ranged from charges that they constituted "bureaucratic interference with the sacred rights of the American home" to condemnation of them as "tending to promote Communism."

But the longest, bitterest, and costliest campaign the A.M.A. ever waged was its fight against any form of compulsory government health insurance, or what it has loosely called "socialized medicine." In that contest, like all the others, the A.M.A. possessed unique advantages. In 1964, for example, its total operating budget was twenty-three million dollars—or more than twice as much as that of its nearest rival, the A.F.L.-C.I.O. A large part of that sum paid for the upkeep of some nine hundred employees, including seventy publicists, at its headquarters in Chicago, as well as twenty-three members of its lobby office in Washington. Most of the Association's revenue came from advertisements in its various periodicals, but a full third of it was contributed in the form of dues by its two hundred thousand members—who possess some unique advantages, too. Among them are *their* incomes, which average out to the highest of any professional group in the country, and their prestige, which for many years survived even their own unwitting subversion of it. Politically speaking, these advantages are unmatched by any other lobby in the country. Even so, they scarcely compare to still another advantage with inestimable political potential—that doctors are practically ubiquitous; every day in every part of the coun-

try they can converse with, and possibly convert, some two and a half million patients.

The struggle over government health insurance raged back and forth across the country for more than a generation, it cost the A.M.A. and its affiliates and allies something on the order of fifty million dollars, it gave the Association a reputation that would not be envied by the Teamsters, and it left political wreckage that may not be cleared away for more than another generation. The long war finally ended in the summer of 1965 with enactment of the bill that is commonly known as Medicare—making the United States the last industrialized nation in the West to adopt a compulsory health-insurance program. When the bill passed, members of both political parties in both houses of Congress agreed that their votes on the measure were the most important ones that they had ever cast. "Medicare was the greatest social innovation since the passage of the original Social Security Act of 1935," Senator Clinton P. Anderson, Democrat of New Mexico, who was co-sponsor of the bill, said shortly after it passed. "The doctors claimed that the fight was over government control of medicine. That wasn't it at all. The fight was over whether decent medical care is a basic right—like the right to food, shelter, clothing, and education. The people and Congress decided that it was. I guess it could properly be called the fifth human right."

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WHEN President Johnson flew to Independence, Missouri, on July 30, 1965, to sign the Medicare bill—officially designated Public Law 89-97—at the Harry S. Truman Memorial Library, he gave Mr. Truman credit for originating the legislation. Then he said, "We marvel not simply at the passage of this bill but what we marvel at is that it took so many years to pass it." While it is true that Mr. Truman was the first American President to make a public endorsement of compulsory health insurance, the idea was actually a good many years older than President Johnson indicated, and the new legislation had taken even longer to be passed. The idea originated, of all places, in Prussia when Bismarck, in 1883, instituted a medical-insurance plan, as a means of weakening trade unions and keeping the people beholden to the government—that is, to Bismarck. The idea of government medical insurance gradually spread through Europe, and in 1911 Great Britain set up a limited program to insure low-income groups against some of the high costs of sickness. The British program created interest in this country, and before it was a year old, Louis D. Brandeis, then a lawyer in private practice, urged the National Conference on Charities and Correction, a central organization made up of public and private welfare agencies, to support a broad program of social insurance, including medical insurance. His suggestion was accepted, and during the Presidential campaign of 1912 the Progressive Party, under Theodore Roosevelt, picked it up and made national health insurance one of the main planks in its platform.

That same year, the American Association for Labor Legis-

lation—consisting of trade unionists, social reformers, economists, political scientists, and lawyers who had led the fight for state workmen's-compensation laws a few years earlier—set up a Committee on Social Insurance to try to devise a practical way of protecting the public against economically ruinous medical bills. (All in all, 1912 was a big year for medicine; according to an estimate made by Professor Lawrence Henderson, of Harvard, it also marked a significant dividing line in medical care—when "for the first time in human history, a random patient with a random disease consulting a doctor chosen at random stood better than a 50-50 chance of benefiting from the encounter.") In 1913, the Committee on Social Insurance reported back to its parent organization with a recommendation for a system of compulsory health insurance to be administered by the states. By 1915, the committee had drafted a model bill, and the following year several state legislatures began considering it seriously—and, for the most part, favorably.

The A.M.A. liked the idea, too, in those days. "The time has come when we can no longer resist the social movement, and it is better that we should initiate the necessary changes than have them forced on us," the trustees of the Association noted in a report on the subject of health-insurance coverage that was submitted to a meeting of the A.M.A. House of Delegates in 1916. Statements such as this one would be considered flagrant heresy a few years later, but in those days, when a long tradition of leadership by men like the Mayo brothers had made the A.M.A. into a universally respected scientific organization, sentiments of that sort did not seem unusual at all. Furthermore, the years just before the First World War in this country were a time of growing indignation against the brutal injustices of the industrial revolution, which were then being documented by writers like Lincoln Steffens and Upton Sinclair. Another A.M.A. statement of this period touched on the medical profession's concern and responsibility for the lot of the workingman: "The introduction of these [state health-insurance] bills marks the inauguration of a great movement which ought to result in an improvement in the health of the

industrial population and improve the conditions for medical service among the wage earners." The A.M.A.'s enlightened, if short-lived, view at that time reflected the influence of Dr. Alexander Lambert, Theodore Roosevelt's personal physician and a figure of great prestige within the medical profession. As chairman of the A.M.A.'s Social Insurance Committee, Dr. Lambert reported to the Association that his group had looked into the possibilities of voluntary health insurance under private control and, having found it unworkable, recommended adoption of a compulsory system under government control. The A.M.A.'s Council on Health and Public Instruction supported him. "Blind opposition, indignant repudiation, bitter denunciation of these laws is worse than useless," the Council informed the House of Delegates. "It leads nowhere and it leaves the profession in a position of helplessness if the rising tide of social development sweeps over [it]. . . . In the end the social forces that demand these laws and demand an improvement in the social existence of the great mass of the people of the nation will indignantly force a recalcitrant profession to accept." The A.M.A. delegates endorsed this prophetic statement without dissent, and by 1917 the model health-insurance bill had been introduced in sixteen state legislatures.

One of the earliest casualties of any war is social reform. When the United States entered the First World War, the health-insurance proposals, along with other remedial legislation, were shelved for the duration. Opponents of the idea, who turned out to be far more numerous than had been suspected, took the opportunity to group their forces. A great many doctors around the country—particularly practitioners in rural areas, who not only outnumbered their city colleagues but were in all ways more conservative—started writing letters to the *Journal* of the A.M.A. to express disapproval of the model bill. Their complaints—which were even more bitterly and persistently expressed on the local level—led county and state medical societies to send the A.M.A. official resolutions condemning its stand. Leaders in the pharmaceutical industry (who felt that government control over medicine would

lead to government control over medication) and leaders in the insurance business (who felt that government health insurance would lead to government insurance of all kinds) joined the attack on government intervention. In the view of Frederic L. Hoffman, a vice-president of the Prudential Insurance Company of America and one of the chief spokesmen for the opposition, the whole health-insurance movement was clearly a German plot.

By 1920, the outcry against the model bill had become so clamorous that the A.M.A.'s House of Delegates reversed itself and passed a resolution declaring its "opposition to the institution of any plan embodying the system of compulsory contributory insurance against illness." Dr. Lambert was president of the Association that year, and during the session, a tumultuous one, delegates periodically broke into the chant "Get Lambert!" They got him by way of their resolution. That event marked a profound change in the A.M.A. Before long the great leaders in medicine—men like Lambert and the Mayos—disappeared for good from the Association's roster of officers. From that time on, the A.M.A. was largely run by what its detractors call "medical politicians." The 1920 resolution killed the model bill as far as the state legislatures were concerned, for these bodies had long since accepted organized medicine's authority in the field, and had, in effect, turned over to medical practitioners the final decision on all medical legislation. In the *laissez-faire* abandon of the twenties, few seemed to care.

If prosperity was the general rule of the twenties, no one had to look far for exceptions. Among millions weakened by impoverishment, thousands were dispatched each year, with terrifying regularity, by illnesses that they could not afford to have treated. Finally, a few people of influence who did care about the poor, including those who were made poor by medical bills, decided to do something about it. At their prompting, eight leading foundations got together in 1927 and set up a Committee on the Costs of Medical Care, consisting of prominent figures in the fields of medicine, public health, social work, education, and public affairs. Over a period of five

years, the committee published twenty-eight reports, which constituted the most comprehensive survey of medical economics ever made up to that time. In 1932, the committee released its majority report, under the signature of its director, Dr. Ray Lyman Wilbur, a past president of the A.M.A. who had just served as Secretary of the Interior under President Hoover and at this time was president of Stanford University. Dr. Wilbur, and a majority of the committee's members, came out for group practice for doctors and voluntary health insurance for their patients.

The A.M.A. saw red. Commenting on the report, its *Journal* dismissed group practice as a system of "medical soviets," and then said, "The alignment is clear—on the one side, the forces representing the great foundations, public-health officialdom, social theory—even socialism and communism—inciting to revolution; on the other side, the organized medical profession of this country, urging an orderly evolution."

To the A.M.A., the alignment became clearer and clearer as time went on. Back in 1929, the program that was to become Blue Cross had been started in Texas—not so much to protect the patient against hospital costs as to protect hospitals against non-paying patients—and when the American Hospital Association endorsed the plan in 1933, the A.M.A. attacked it as a "half-baked scheme." The following year, the American College of Surgeons, one of the earliest organizations for specialists, announced its support for Blue Cross, whereupon the A.M.A. rebuked the surgeons for "an apparent attempt to dominate and control the nature of medical practice."

During Franklin D. Roosevelt's first term in office, it was clear that a large percentage of the American people were not just ill-fed, ill-clad, and ill-housed but also simply ill and unable to pay for medical care. Most charitable agencies, like practically everyone in those days, were short of funds, and they couldn't begin to cope with the medical needs of the millions who were out of work. In 1934, President Roosevelt appointed a Committee on Economic Security and assigned it the task of drawing up plans for a social-security system that

would give Americans some measure of protection "against misfortunes which cannot be wholly eliminated in this man-made world of ours." The committee recommended federal pensions, unemployment insurance, and direct assistance for certain categories of the needy, and suggested that an official study be made of the practicability of national health insurance. When the social-security bill came up before Congress the following year, it contained a sentence giving the Social Security Board, which was to administer the law if it passed, the power to make such a study and to report on it to Congress. According to the committee's staff director, Edwin Witte, "that little line was responsible for so many telegrams to the members of Congress that the entire social-security program seemed endangered." To save the program, the House Committee on Ways and Means, on orders from the White House, struck out the line.

Dr. John A. Kingsbury, a former Commissioner of Charities in New York City, attributed the protests to the A.M.A. and its state and county societies. "Like ordinary lobby groups they have sent thousands of telegrams to the President and to Congress, seeking to exert pressure without reference to the merits of the proposal under consideration," he said at the time. "They have sought to use personal influence on those in high places, have spent tens of thousands of dollars in publicity campaigns of misinformation, have spread false rumors, and have resorted to scurvy attack on personalities." Dr. Kingsbury soon had further reason to regret both the A.M.A.'s tactics and its influence. When he made his statement on lobbying, he was secretary of the Milbank Fund, one of the foundations that had underwritten the Committee on the Costs of Medical Care, and both he and the fund's chairman, Albert G. Milbank, who was also chairman of the Borden Company, were outspoken advocates of national health insurance. According to *Fortune*, "the connection between the Fund and the Borden Co. was made clear to the medical profession, and a number of local medical journals began hinting through editorials that a boycott of Borden products would have a salutary effect on the Fund." Shortly after the hinting began, the

Philadelphia Medical Roster & Digest was able to inform its readers that "one of the foundations has already modified its elaborate plan to sell state medicine for the simple but effective reason that many discerning physicians had stopped buying a certain product." The product was Borden's irradiated evaporated milk for infants. In March, 1935, Milbank announced that his fund did not endorse national health insurance after all, and not long after that Dr. Kingsbury was dismissed.

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IN POLITICS, a man who commands a consensus representing as much as two-thirds of his colleagues or his constituents in any given situation is looked upon with awe. If he has any percentage above that, people start muttering about tyranny. When the A.M.A. went into politics full time, beginning in 1935, its idea of a consensus among its members was that every single one of them had to support it all the time if their freedom was to be preserved. In an emergency session of the House of Delegates called early in 1935, while the social-security bill was pending before Congress, the A.M.A. again went on record against "all forms of compulsory sickness insurance." Two weeks later, to the astonishment of officials at the A.M.A. headquarters, in Chicago, the California Medical Association came out in favor of compulsory health insurance on the state level. After some pointed reminders from Chicago, the California doctors backed down. (In fact, they backed down so far that within a few years they were to spend a quarter of a million dollars to defeat the program they had previously endorsed.)

Then, in 1936, the federal government announced the findings of a two-year national-health survey, which showed that ninety per cent of the people in the country were getting inadequate medical care. In response to this survey, rebellion broke out in the A.M.A. itself. When the House of Delegates held its 1937 convention, the New York delegation submitted a resolution urging acceptance of the principle that "the health of the people is the direct concern of government," and advocating that the A.M.A. proceed to formulate a "national health policy." One observer noted that "hectic commotion

and violent waving of fists resulted," and the *Journal* reported that the proposal was "rejected with an enthusiastic unanimity."

Not all doctors were content to regard the matter as settled. A few months later, a group of four hundred and thirty internationally known specialists, deans of medical schools, and public-health officials formed a Committee of Physicians for the Improvement of Medical Care and issued a declaration that included most of the proposals the New York delegation had submitted to the House of Delegates. To meet this flank attack, an editorial in the *Journal* of the A.M.A. demanded that the signers of the declaration issue "prompt disclaimers" of their statement that the health of the people is the direct concern of government and went on to question the motives of some of them, naming names and suggesting that they were angling for government favors. At first, the members of the new committee had circulated their declaration only among doctors, but now they released it to the press. After that, the *Journal* refused to print articles or letters from any members of the committee.

The quarrel created lasting animosities, and drew a good deal of criticism on the A.M.A. from a number of the country's foremost physicians as well as from laymen. "Such methods of handling differing opinions coming from without, or dissent arising from within, are the tactics of sectarians, not of scientists," wrote Michael M. Davis, a well-known sociologist and medical administrator, who had been a leader of the health-insurance movement almost from its beginnings in this country. "They have had two unfortunate results. They have weakened confidence in the organized medical profession among considerable sections of the public. They have promoted among physicians an emotional approach to the economic and social aspects of medicine which warps and often inhibits an intelligent participation in problems in which the future of medicine is much involved." Actually, at that time doctors were far less united in their opposition to government participation in health matters than they came to be later. Polls showed that a majority of laymen supported national

health insurance and that a majority of doctors agreed with them. Presumably, the two groups also agreed that more money should be available to pay for medical care. A study made several years before had shown that more than half the country's doctors had annual incomes of less than thirty-one hundred dollars. The A.M.A. had a solution for that problem, too—cut down on the number of doctors by restricting the number of students in medical schools, or what it called "professional birth control."

The A.M.A. found itself threatened by a second attack in 1937 that was in some ways far more serious. That year, several employees of the federal Home Owners' Loan Corporation, assisted by a few young New Deal attorneys, organized the Group Health Association of Washington, D.C. Their plan, designed for low-income government workers, was to hire doctors on a salary basis and to provide members with almost complete medical care for a monthly fee of two dollars and twenty cents apiece. Before the program got under way, the *Journal* warned doctors to stay clear of it, declaring, "Physicians who sell their services to an organization like Group Health Association for resale to patients are certain to lose professional status." Except for federal health insurance, nothing has alarmed organized medicine more than the idea of a group of people who want to pay their medical costs ahead of time getting together with a group of doctors who are willing to treat them for a stipulated monthly fee—an arrangement known as a prepaid group-health plan.

Back in 1929, Dr. Michael Shadid, a Syrian immigrant who had made a lot of money in private practice and wanted to share it, donated twenty thousand dollars to the Farmers Union Hospital Association, in Oklahoma, and, with its assistance, set up the nation's first medical coöperative, the Community Hospital-Clinic, at Elk City. The local medical society, which Dr. Shadid had belonged to for twenty years, tried to talk him out of going ahead. When that failed, it tried to expel him. When that, too, failed, the society disbanded and reorganized without him. After twenty years of harassment by the society, which refused membership to doctors participating in

the program, the clinic finally sued the society for three hundred thousand dollars, charging restraint of trade. Eventually the society settled out of court, and agreed to admit the proscribed doctors to membership.

The A.M.A.'s case against prepaid group-health plans has been essentially the same as its case against health insurance. Both grew out of a "statement of principles" that the House of Delegates adopted in 1934 which asserted, among other things, that "no third party must be permitted to come between the patient and his physician in any medical relation." In much of its literature, the A.M.A. has referred to this as "the sacred doctor-patient relationship"—or, if it is feeling uneasy, as "the sacred patient-doctor relationship." Whatever it is called, an almost magical quality has been assigned to it. There is no doubt that a patient's belief in his doctor's powers has often been the best medicine available to either of them. Few potions in the old-fashioned country doctor's little black bag had as much effect as his kindly demeanor and his comforting hands.

To an extent, faith in one's doctor is still sometimes vital. As Bronislaw Malinowski, the famous anthropologist, has written, "Magical beliefs and practices tend to cluster about situations where there is an important uncertainty factor and where there are strong emotional interests in the success of action." Aside from religious practices, probably no human situation fits this description better than that of a person undergoing medical treatment. "The basic function of magic," according to Talcott Parsons, professor of sociology at Harvard, "is to bolster the self-confidence of actors in situations where energy and skill *do* make a difference but where, because of uncertainty factors, outcomes cannot be guaranteed. This fits the situation of the doctor, but in addition on the side of the patient it may be argued that *belief* in the possibility of recovery is an important factor in it. . . . Of course, this argument must not be pressed too far."

No one has pressed the argument further than the leaders of the A.M.A., who have used it as their chief argument against any interference with the intimacy of a doctor's re-

lationship with his patient. Advocates of government health insurance have argued that the only relationship it necessarily interferes with is the one between a patient and his pocketbook. Moreover, some of them have pointed out, it was in the depths of the Depression that the A.M.A. adopted its "statement of principles," and in those days a relationship with any doctor outside a charity ward was a luxury that not many Americans could afford. Various developments in medicine since then have diminished the intimacy of the relationship still further. Thirty years ago, for example, the average doctor treated perhaps fifty patients a week, and now the number has trebled. Moreover, the rapid growth of specialization (today there are some fifty specialties and subspecialties) has cut the number of family doctors from one for every nine hundred people to one for every three thousand. In sum, the average patient nowadays gets less of his doctor's time than a patient did in the thirties, and is more likely to be sent on to a specialist, whom he may never have seen before. Should his illness require that he be sent to a hospital—the time when he most needs the security of such a relationship—a host of third parties, including internes, residents, nurses, orderlies, technicians, are bound to come between him and his doctor.

Regrettable as the loss of personal attention may be, the scientific advances that have taken its place seem—to many people, at any rate—a worthy substitute. Selig Greenberg, a journalist and medical writer, has pointed out that there is a certain irony in the A.M.A.'s defense of the inviolability of that relationship, since it has consistently encouraged the kind of modern medical practice that makes it less and less attainable. In Greenberg's view, "all the befuddlement of inane oratory cannot quite obscure the fact that the medical profession is using the largely mythical rapport between doctors and patients as a weapon in the battle to protect its lucrative privileges."

On the subject of how doctors should be paid, the A.M.A. has been uncompromising. The 1934 "statement of principles" stipulated that "however the cost of medical service may

be distributed, the immediate cost should be borne by the patient . . . at the time the service is rendered." In further support of what is known in medical circles as the "fee-for-service" doctrine, the House of Delegates later passed a resolution stating, "Any system of medicine that offers complete coverage and relieves the recipient of making any direct contribution for his own medical care will lower his sense of responsibility for his own health and that of his family and will eventually depreciate the quality of medical services he receives." In substance, the fee-for-service doctrine means that only a doctor can determine what his services are worth.

To critics like Greenberg, the doctor-patient relationship is sacred to doctors largely because it keeps outsiders from comparing or questioning fees. Another well-known medical writer, Richard Carter, has claimed that the A.M.A.'s opposition to any large-scale health-insurance program "has been based on the fear that economic plans of that scope would require public support so extensive as to necessitate public control." And he continued, "The knowledge that public control will curtail the profession's fee privileges underlies organized medicine's position on health insurance and on every other controversial issue in the field."

The A.M.A. has also often spoken of the virtues of "free-enterprise medicine." In a sense, it is the purest form of free enterprise, because under it every doctor is an individual entrepreneur—entirely free to practice as he sees fit and to charge what he wants. At the same time, the A.M.A. quietly opposes what it calls "corporate medicine," which, despite its ominous sound, means merely that a doctor chooses to work for a salary, whether on the faculty of a medical school, in a research foundation, at a hospital, in government service, or in private industry. The proportion of salaried physicians in this country has risen in the past thirty years from about a seventh to better than a third, so the A.M.A. has done no more than hint that this means of earning a living is unethical. However, it has not attempted to stop some county medical societies from expelling members who accept salaries.

The pressures on doctors who defy any of the A.M.A.'s

basic precepts have often been severe. By 1938, the Group Health Association of Washington had enrolled twenty-five hundred members and their dependents, who were taken care of by seven doctors working on salary. The group was small, but the fact that it was run by and for government employees added to its importance as a precedent. At first, the A.M.A. appealed to the seven doctors to withdraw from the program. When they refused, the District of Columbia Medical Society sent all its members a so-called white list of approved organizations that they could belong to. The Group Health Association was not among them. When the seven doctors still refused to give up their salaried group practice, they found that they were no longer being called in for consultations and that referrals of patients, the staple of specialty practice, abruptly stopped. Still they stuck it out. The District society then persuaded most of the hospitals in the area to deny staff privileges to the rebels and beds to their patients. One doctor who had taken a woman patient to a hospital for surgery and had already given her morphine was suddenly refused access to the operating room; after a four-hour quarrel with the hospital director he moved his patient to another hospital. A man with acute appendicitis was dismayed to learn that his own doctor would not be permitted to operate on him, and that the operation would not be performed at all unless he agreed to withdraw from the program. One stubborn old woman who had been run over by an automobile was finally forced to leave the hospital to which she had been rushed because she persistently refused to be treated by anyone but a Group Health Association doctor.

Just when the doctors in the program were about to admit defeat, Thurman Arnold, the chief of the Antitrust Division of the Department of Justice, heard about what was going on and sent out some investigators to collect evidence, which he then presented to a grand jury. The A.M.A. and the District of Columbia Medical Society were indicted for violation of the Sherman Antitrust Act. The government lost the case in a lower court but won a reversal in a higher court and made it stick in the Supreme Court. In a unanimous decision, written

by Justice Owen J. Roberts, the Court held that the A.M.A. was guilty of a criminal action, and went on to say:

> Professions exist because people believe they will be better served by licensing specially prepared experts to minister to their needs. The licensed monopolies which professions enjoy constitute in themselves severe restraints upon competition. But they are restraints which depend upon capacity and training, not privilege. Neither do they justify concerted criminal action to prevent the people from developing new methods of serving their needs. The people give the privilege of professional monopoly and the people may take it away.

The government had won its case against the A.M.A. because it had been able to prove that a conspiracy existed. And it had been able to prove that a conspiracy existed because the A.M.A. hadn't bothered to conceal it. Afterward, the A.M.A. continued to oppose prepaid group-health and insurance plans but employed somewhat different tactics. "Recently, organized medicine has conveyed veiled threats to doctors participating in disapproved plans by outspoken condemnation of such plans in ethical terms," the *Yale Law Journal* commented several years after the Court's decision. "Such indirect, less overt opposition probably discourages physicians from affiliating with disapproved plans, but is less susceptible to antitrust prosecution." Indirect methods were apparently enough to do the job, for the article added, "Defiance of A.M.A. authority means professional suicide for the majority."

Nor was there any way for most of the victims of reprisals to fight back. Courts invariably ruled that expulsion from, or denial of membership in, a county medical society—often entailing a loss of hospital privileges and specialty accreditation, which could mean the loss of a doctor's practice—did not deprive a doctor of any property right, and as long as the society didn't violate its own rules, they rarely intervened; that is, unless a society ignored the Supreme Court decision and excluded a member for participating in a group-health plan. Ultimately, then, nonconformists were pretty much at the mercy of their

colleagues. "The doctor who challenges A.M.A. authority to determine his method of practice," the *Yale Law Journal* noted, "is tried and judged by his fellow physicians who may have an economic interest in proscribing his allegedly offensive conduct."