HOW THE SYSTEM GREW Rx

Most of the health care system's present inadequacies arise from its past triumphs: the advances of science, education, professionalism and, finally, political organization. From the public's point of view, these successes have been a double-edged sword, giving doctors both the power to heal and the freedom to tyrannize. Indeed, the apparent intransigency of the medical establishment, its peculiar unwillingness to accept advice, is an indirect consequence of the long struggles for professional status and political power.

Over the decades doctors have fought hard to be king of the hill; they are not eager to dismantle the monarchy. Many of the defects one discerns in our Federal health programs—the soaring costs, the evidence of shoddy practice and the mind-boggling bureaucracy of it all—are a legacy of the profession's political opposition to these programs. The political conflict between physicians and patients has been simmering, and occasionally boiling over, since 1912. The public has won some battles, but the doctors keep winning the war.

We tend to forget how difficult and tardy was the triumph of science in medicine. As Herman and Anne Somers point out in *Doctors, Patients & Health Insurance,* Galen's 2nd-century assertion that pus in wounds was a condition leading to healing was not seriously challenged until the 13th century; and "the hostility of profession and populace alike to the necessity of surgical cleanliness . . . led to a 600-year delay before it was accepted." William Harvey, who discovered the circulation of blood (1628), claimed no man over 40 accepted his new theory. "I not only fear injury to myself from the envy of a few," he wrote, "but I tremble lest I should have mankind at large for my enemies, so much does wont and custom . . . and respect for antiquity influence all men."

Even in relatively modern times, medical progress encountered strong opposition. In 1840 Dr. Oliver Wendell Holmes was unable to convince obstetricians that they were inadvertently transmitting puerperal fever to patients in lying-in hospitals. And as late as 1880 Joseph Lister's supporters failed to persuade colleagues that they ought to censure doctors who harmed their patients by ignoring antiseptics. (Nowadays, the Somers remind us, a different attitude prevails: "In contrast to the lonely isolation of earlier medical scientists and the widespread apathy or resistance to their findings, virtually the whole nation was leaning over the shoulder of Dr. Jonas Salk as he completed his research on polio vaccine.")

In an earlier America, too, large portions of the citizenry abominated the physician no less than the incipient science he was a part of. To further complicate matters for him, any business he might manage to build could be swept away by cutthroat competition. Free enterprise was rampant. Medical societies were too weak to help, and medical schools were too greedy to care. As Jay Heubert has observed, in a paper on "The Early History of Health Policy," the healing world "was full of . . . homeopaths, eclectics and members of many other unscientific cults, and medical schools dedicated to each of these approaches proliferated."

Most of these schools were opportunist in motive and shabby in performance. Grave-robbing for anatomy classes, notes Dr. Rosemary Stevens in *American Medicine and the Public Interest,* "was frequent and fashionable." (Students at Winchester Medical School in Virginia went so far as to snatch the body of Owen Brown, John's brother, in the thick of the fighting at Harper's Ferry.) Gaining admission to one of these institutions was usually as simple as paying the tuition fee. Hardly a single novitiate had finished high school; most had dropped out of grade school.

Despite the discouraging atmosphere, some doctors began forging a professional alliance, organizing state-wide societies, setting standards of practice, and distributing medical licenses. The societies competed savagely for power, though, and the public tended to

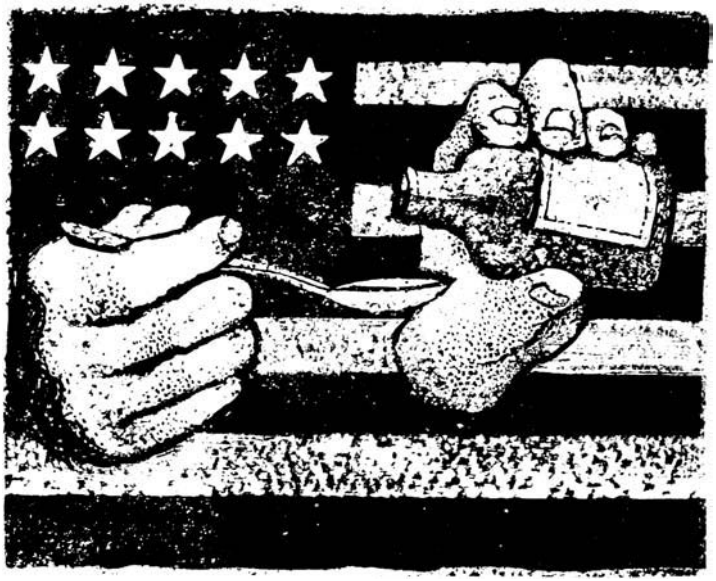
view all pleas for professionalism as ill-concealed bids to build a medical oligopoly. Those who imposed licensing and education restrictions, complained one observer in 1833, did so "ostensibly for the protection of the sick, and the encouragement of medical science, but in truth, for the pecuniary benefit of a few aspiring physicians." (The more things change, the more they remain the same.)

By 1830 there were medical societies in nearly all the states of the Union; and the move toward self-regulation, timid as it was, led in 1847 to the founding of the American Medical Association. In its infancy the AMA espoused an idealism then rare in the annals of American health care, declaring that its purpose was "to promote the science and art of medicine and the betterment of public health." Until World War I, the AMA remained reasonably true to its objective, working to reduce quackery, raise quality and, in general, to protect the public from medical cannibalism. For a time the association even flirted with the prospect of "socialized medicine"; but that frail impulse, which flowered in the early years of the present century, soon wilted before the membership's desire to cultivate more lucrative gardens.

The association's main ambition during the 1800s was to convert the medical profession into a "closed shop"—that is, to establish an enforceable sequence of schooling and licensing, with centralized control reposing in the AMA's national office. Gradually, by hitching its feeble star to the better medical schools and painstakingly building a pyramid of medical societies from the county level on up, the AMA won a popular franchise both within and without the medical profession. By 1902 the pyramid was complete in nearly every state, a signal that the AMA might at last be strong enough to introduce major reforms. Whereupon, and for the first time in its history, it carried its fight to Washington.

AMA leaders pressed Congress to pass a "national licensing standards" law aimed at overcoming—in the words of the AMA *Journal*—"the present anomalous conditions regarding the regulation of the practice of medicine in the various states." At the same time the AMA recommended that the White House be empowered to appoint a national board to examine physicians seeking posts in the Federal government. Finally, and in retrospect, uncharacteristically, the AMA called for the creation of a new, Cabinet-level Department of Health.

None of these measures succeeded (though Congress did authorize a Public Health and Marine Hospital Service, destined in a decade to become the Public Health Service). Too much opposition had been raised by state licensing boards jealous of their prerogatives, and by medical schools fearful that Federal standards would put them out of business. They were probably right. As late as 1900 only six states had any requirement for pre-medical education, and five of those were satisfied with schooling below the high school level. Moreover, the training offered by nearly all medical schools, complained a contemporary professor at Johns Hopkins, was "simply horrible." The Harvard Medical School did not put the stethoscope in its curriculum until 30 years after its invention.



It was clear to AMA leaders that they would have no political clout until they cleaned up the mess in education. Accordingly, in 1904 the editors of the *Journal* fired an opening shot, noting that the number of medical schools had increased since 1880 from 90 to 154, and that they were turning out twice as many doctors as were needed to maintain "absurdly crowded conditions." The editorial achieved an exquisite balance between self-interest and selflessness, a by now familiar trademark of AMA literature. On the one hand, it called for fewer doctors and higher fees; on the other, it asked medical schools to introduce four-year curricula and recommended a shutdown of the many private, fly-by-night diploma mills pocking the landscape.

The AMA soon found an ally in the Carnegie Foundation for the Advancement of Teaching, which underwrote a study of medical schools by one of its staff members, Abraham Flexner, and Dr. Nathan Colwell of the AMA's newly organized Council on Education. The two men visited every medical school in the country, and their findings, published as the Flexner Report in 1910, rocked the medical world. Only Johns Hopkins, Harvard and

Western Reserve received a clean bill of health. The rest—particularly the small, private institutions—were variously described as "wholly inadequate," "miserable" and "utterly wretched." Kentucky was singled out as "one of the largest producers of low-grade doctors in the entire Union"; Chicago, as "the plague spot of the country."

The Flexner Report was a watershed. In the wake of its revelations, 92 schools either merged or closed their doors. By 1915 the remaining 85 had minimum entrance requirements of one or two years' college preparation; and state licensing standards were quickly revised to match the medical schools' new strictures.

Almost everyone applauded these overdue reforms at the time, but looking back we can discern some melancholy consequences that continue to haunt us. In the first place, by cashiering the weaker schools, the AMA and its minions gained virtually total control over the distribution of manpower for the health care system. From that point on the medical hierarchs could manipulate the supply of physicians in the profession's narrow interests (always in the name of higher standards). As a result, the number of doctors per 100,000 population slid from 157 in 1900 to 133 in 1960, having reached a low of 128 in 1930. The ratio began to inch up—it is now back to 151, still below turn-of-the-century levels—only after Congress authorized Federal aid to medical education, over strong AMA objections but with the concurrence of most medical schools.

At the nadir of the Great Depression, with doctors' incomes sagging and the birth rate plummeting, the AMA announced it would never again be caught with an "oversupply" of doctors scrambling for a dwindling number of patients. Subsequently the AMA kept a firm rein on supply, insisting in the face of mounting evidence to the contrary that there was no doctor shortage. In 1949 a study by the U.S. Public Health Service put the shortage at 45,000; a decade later Ward Darley, executive director of the Association of Medical Colleges, warned of an approaching manpower crisis, "the most serious that medical education has faced since the Flexner Report." Finally, in 1963, the AMA retreated, allowing Congress to pass the Health Professions Educational Act, which eventually assisted in the creation of 20 new medical schools and pumped expansion funds into existing ones. Even today, it has been estimated that 20,000 *fully qualified* applicants are rejected each year by our 114 medical schools.

The long-range effect of AMA-induced shortages has been to raise fees and permit doctors to practice where they please—not necessarily where the most patients live, but more often where the most money is being spent. A more truly competitive system would have driven at least some doctors out of the high-rent districts and into the ghettos and rural areas.

It is impossible to say to what extent the history of American medicine has skewed the distribution of services and fattened physicians' incomes; nor can anyone estimate with precision to what degree a sharp increase in doctor manpower, even now, might redress the balance and lower the fees. Curiously, no physician I have interviewed, including the reform-minded ones, cares to speculate on the question. Whole books have been written on the high cost of health care without once drawing a connection between supply and price. Dr. Rashi Fein, who has published a definitive study on *The Doctor Shortage* (Brookings Institution, 1967), may have come the closest when he observed that physicians' fees rose more rapidly from 1956-65 than did the overall consumer price index, and ventured that this could be "evidence of a shortage of services."

Independent Spirits

A second unsought effect of the Flexner Report was the almost limitless freedom it gave physicians in their style of practice. For if the AMA was miserly in its recruitment of acolytes, it was most generous to those few it consented to induct. "The medical profession," the AMA's Council on Education declared in 1914, "approves the system which requires the same general professional education for all its members. . . . One may select any specialty he chooses and may adopt any method of treatment which his educated judgment dictates. He may use large doses or small, massage or electricity. What the State requires for one body of practitioners it should not abate in favor of another."

This virtual carte blanche rendered each doctor the primary judge of his own performance. We have been struggling with the consequences ever since, trying in vain to introduce the notion of accountability to a fiercely independent profession. Last December the debate flared anew when delegates to the AMA's annual convention denounced an agreement their leaders had made with Federal authorities. The agreement, arising from an amendment to the Social Security Act that Senator Wallace F. Bennett of Utah had introduced and Congress had passed during the fall, called for a nationwide network of physicians—a Professional Standards Review Organization (PSRO)—to monitor the work of their colleagues in cases subsidized by Federal programs. According to the New York *Times*, "The law [was] bitterly resented by many doctors," and 16 resolutions were submitted demanding its repeal. The one that finally passed merely asserted that "the best interests of the American people, our patients, would be served by . . . repeal" of the PSRO.

What strikes one as strange about all this is the fury of the opposition in contrast to the mildness of the measure. "The law," warned Dr. Malcolm C. Todd, AMA's new president, "poses the greatest threat to the private practice of medicine of any piece of legislation ever passed by Congress." Yet all the law asks is that physicians be accountable to their colleagues—not necessarily to the rest of us—and then just in Federally subsidized cases. Only a profession long accustomed to the protections of ex-

clusivity and the privileges of unchallengeability could summon so emotional a response to so sensible a proposal.

Though the Flexner Report undoubtedly resulted in a better breed of doctors and a higher standard of care, it tended to reenforce the physician's image of himself as a solo practitioner who, within broad limits, was free to chart an independent course—free, that is, to treat whom he pleased where he pleased at whatever price he pleased. Granted, this image has blurred over the years in the face of a modest trend toward group practice (of which more later) and of recent Federal incursions. Yet inside doctors' heads it remains intact. It is what Dr. Russell B. Roth, the AMA's outgoing president, had in mind at the last convention when he sang to the tune of "It Ain't Necessarily So":

There's nothing but misery
and woe
To expect from PSRO,
But thanks to the amendment
and Senator Bennett
There's no other way to go.

The reforms that attended the Flexner Report also confirmed the AMA's new reputation as a mover of men and a maker of marvels. Thereafter it was inevitable that the association's role should become increasingly political, its spokesmen lobbying and agitating in the name of what appeared to be a remarkably united profession. The upshot has been a succession of political skirmishes between physicians and the public, punctuated from time to time by major disputes over national health insurance, a blessing that often seemed within our reach but so far has exceeded our grasp.

Americans had at least four different opportunities to erect a national health insurance structure: before World War I, during the Depression, after World War II and, most recently, during the late '60s —the period that gave us Medicaid and Medicare. In each case, our failure to take decisive steps perpetuated a health care and health insurance vacuum that came to be filled by private and quasi-private institutions like Blue Cross, commercial health insurance plans and various forms of group medical practice. Some of these were uniquely American inventions meant to keep at bay the demon of "socialized" medicine; and while they have been useful over the decades to millions of citizens, they have spawned new and powerful political interest groups, each dedicated to its own survival and to the suppression of national health insurance. Increasingly, then, health reformers have been playing Sisyphus to the medical profession's Zeus, with the added discouragement that with every new disappointment the hill grows steeper.

The First Climb

Contrary to popular mythology, however, in the beginning AMA political policies were astonishingly progressive; its leaders arrayed themselves alongside the health reformers and helped push the stone up the hill. They campaigned successfully for a Pure Food and Drug bill, which President Theodore Roosevelt signed into law in 1906; and they supported the plank in Roosevelt's 1912 Bull Moose platform calling for compulsory national health insurance. In 1914, after such a bill had been introduced in the Congress, the AMA *Journal* happily announced, "The socialization of medicine is coming." It further affirmed: "The time now is here for the medical profession to acknowledge that it is tired of the eternal struggle for advantage over one's neighbor. . . . Medical practice withholds itself from the field of science as long as it remains a competitive business."

The bill the AMA was bravely promoting envisioned a more thoroughgoing reform of the health care system than do many of the measures being considered by Congress today. Largely the work of the American Association of Labor Legislation (AALL)—a coalition of academics and other professionals, among them Louis Brandeis—it provided for broad medical and hospital coverage plus disability insurance that would pay up to two-thirds of an incapacitated worker's weekly wages. The plan, which included benefits for surgical appliances, prescriptions, eyeglasses, and funerals, was to be jointly financed by workers, employers and the Federal government.

But the start of World War I deflected public attention from social reform to mobilization. It also enabled rank-and-file opposition within the AMA to mobilize, and before long the association's progressive leaders found they had lost their following. Many doctors feared they would end up working for the government; others objected to the legislation's implicit assumption that medical costs were too high for most citizens. They agreed with a colleague who argued that "more is paid for movies and rum than is paid for medical attendance and treatment."

By 1918 the bill was dead and its opponents were in full control of AMA policy. "The AMA," went a resolution passed that year, "declares its opposition to . . . any plan embodying the system of compulsory contributory insurance against illness . . . provided, controlled or regulated by any state or the Federal government." In effect, that statement was sealed in concrete; it remains official AMA policy.

The nation's first flirtation with compulsory health insurance had been fueled by the scientific revolution which, while improving health care, had jacked up the prices and given rise to a bewildering assortment of new specialists, most of whom charged more than did their primary-care colleagues. New medical societies dedicated to the care of eyes, kidneys, bones, and other organs had already begun to appear. These organizations, like the American Surgical Association (1880), were largely apolitical in tone and tendency, preferring the halls of science to the corridors of Congress. Specialists and general practitioners shared a fundamental aversion to the idea of national health insurance. But the groups disagreed on how the medical profession ought to be arranged—the specialists calling for a closed system of licensed specialties, the general

practitioners still pressing for a wide-open profession that left the doctor free to "adopt any method of treatment which his educated judgment dictates."

Confronted with the irresistible force of specialization, that immovable object, the AMA, had its hands full maintaining political unity inside an increasingly fragmented profession. In addition, the technological turnabout in medicine was challenging the sanctity of solo practice and giving rise to cooperative arrangements that enabled physicians to practice under a single roof and use a single store of equipment.

The AMA cast a cold eye on the burgeoning of such group-practice models as the Mayo Clinic, where specialists were king and, in just the years 1912-14, the annual patient load more than doubled from 15-32 thousand. "Will this not mean group against group?" queried the AMA *Journal* in 1921. "May it not be one more step toward the complete elimination of the family practitioner—of the family adviser. . . ? Does it not mean that the family physician is being replaced by a corporation?"

The association cast a still colder eye on prepayment medical plans like the one organized in 1929 by Dr. Michael Shadid in Elk City, Oklahoma. Under Shadid's scheme, for a small annual premium a family was entitled to total medical care at a cooperatively owned clinic and hospital. This was seen by doctors as a frontal assault on fee-for-service medicine. They tried to expel Shadid from the Oklahoma medical society on charges that he had violated medical ethics. The attempt failed, but the AMA's hostility to prepayment plans lingered; and since prepayment is the economic nucleus around which current health maintenance organizations revolve, we find the AMA still fighting a successful rear-guard action against their spread, rewriting Presidential recommendations and bottling up Congressional proposals.

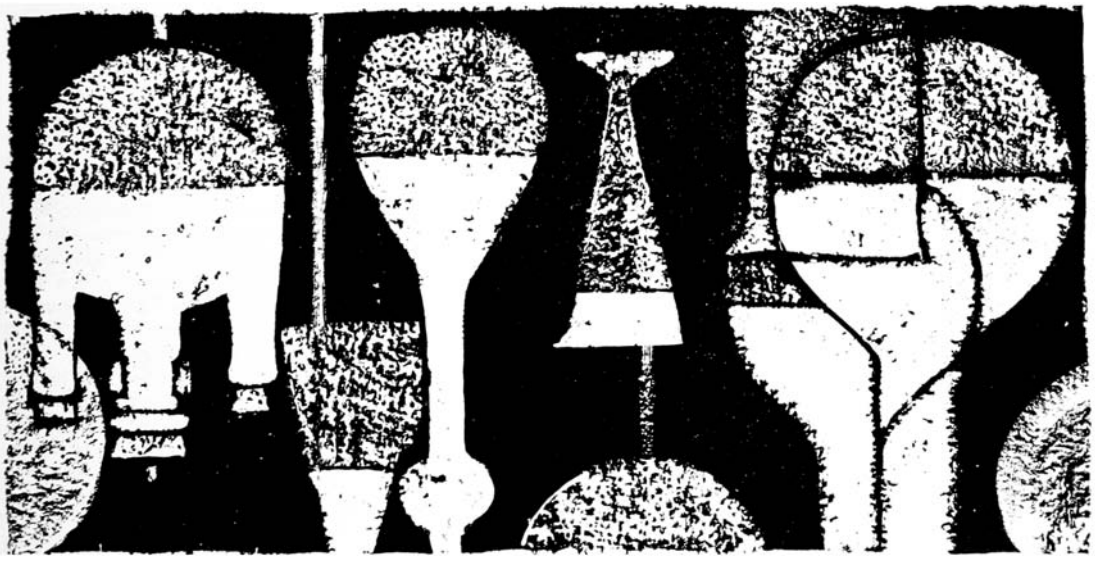
There was a moment in history, circa 1927, when group practice—prepayment or not—was viewed by reformers as *the* solution to spiraling medical costs. "The seriousness of the problem of medical economics," wrote Louis I. Dublin in tones that echo to this day, "has resulted from the present organization of medical services." The answer, he said, was group medicine, which "will undoubtedly eliminate much of the waste of current individual practice and reduce the cost to the patient."

Dublin's optimism proved largely unfounded. By 1970, fully 70 per cent of America's doctors continued to pursue solo fee-for-service practices; and though hospitals and clinics had grown in size and number, the notion of group medicine was still felt by most physicians to be slightly avant-garde and dangerous. Meanwhile, in words all too familiar, the Somers were telling us that "the only promising method" of bringing down health care costs and increasing medical efficiency "now lies in better organization"—i.e., some form of group practice. We have here an outstanding example of our capacity to substitute weak institutions (group medicine here and there) for the radical structures we shrink from building (national health insurance under a reorganized delivery system).

FDR and the AMA

With each new upsurge of political pressure for reform, the AMA grew ever more truculent, its pronouncements ever more strident. In 1930 Congress debated a proposal for channeling Federal funds to state health agencies in an effort to reduce the death rate of mothers and children. The AMA house of delegates said the program "tended to promote Communism."

A larger threat emerged from the Depression and a New Deal Ad-



ministration in desperate need of solutions. In June 1934, President Franklin D. Roosevelt established a Cabinet-level Committee on Economic Security with orders to "study problems relating to the economic security of individuals" and to report back in six months. This was the genesis of Social Security, to be enacted a year later. Because the panel was instructed to explore "all forms of social insurance," including maternity benefits and health insurance, the AMA viewed the development with alarm.

The medical society was further discomfited when the new committee hired two persistent though temperate agitators for health reform, Drs. Edgar Sydenstricker and I. S. Falk. Both men had served from 1927-32 on the influential Committee on the Costs of Medical Care (CCMC), a voluntary, foundation-financed agency that had undertaken the first general review of health care in the United States. Its moderate, something-for-everybody recommendations—more group medicine, more prepayment plans, a continuation of fee-for-service medicine—were regarded by the AMA as possibly subversive. To cite one response, the ideologically trigger-happy *Journal* declared that they raised the question of "Americanism versus Sovietism for the American people."

No sooner did the President's committee convene than angry letters and telegrams from doctors began pouring into the White House. FDR's personal physician, Dr. Ross McIntyre, warned him of "the deep anxiety of physicians on the health insurance issue"; and the President's distinguished in-law—Dr. Harvey Cushing, father of James Roosevelt's wife—lobbied tirelessly for watered-down health legislation. Whatever measures the committee might decide to recommend, he wrote, with some justification, in a letter to the White House, "no legislation can be effective without the good will of the American Medical Association, which has the organization to put it to work."

Roosevelt ultimately relented, hoping to save the Social Security bill by scuttling health reform. None of his committee's major health proposals was sent to Congress; and on August 14, 1935, the President signed a Social Security Act that said not a word about national health insurance. It became known, recalls Dr. Falk in a recent reminiscence, as "the lost reform."

Failure's Dividends

The lessons of "the lost reform" were all too clear. First, the AMA, despite its relatively small membership, emerged as a political Goliath, standing astride the road to health reform and easily turning aside upstart Davids like the CCMC. Second, Congress distinguished itself as a patsy to AMA pressures, permitting doctors to hold the Social Security bill hostage until FDR had paid the ransom. An incident in the House Ways and Means Committee (recounted by Peter A. Corning in an interesting booklet, *The Evolution of Medicare*) suggested that in disputes with physicians most Congressmen had the cowardice of their convictions. In drafting the Social Security bill the committee had included a few words calling for *research* into health insurance, but when the AMA delivered a protesting telegram, the offending words were duly struck.

In the end, it must be recognized that the President's retreat from health reform was caused no more by AMA opposition than it was by lack of active public support. The feebleness of citizen action can be attributed in part to the average American's abiding faith in the medical priesthood; but it stemmed in part, too, from a failure among health reformers to reach out beyond their elite committees and study groups to mobilize public opinion—a failure, in short, to understand the democratic process.

Still, the battle was by no means a total loss. The give-and-take of the Social Security debate in Congress forced the passage of several other important health measures. They included subsidies for maternal and child health, aid to crippled children and, most significantly, grants-in-aid to states for the expansion of public health programs. The effect of these lesser reforms was to establish a Federal franchise in medical fields previously monopolized by states, towns and voluntary agencies. After that, just as the AMA had feared, it was merely a question of time before the Federal government invaded additional areas—supporting medical research, building hospitals, subsidizing medical schools and, eventually, paying the health bills of the elderly and the poor. The way for those innovations was cleared 40 years ago by "the lost reform."

While thus losing ground from time to time, the AMA continued to inveigh against "Marxist medicine" and similar dangers. In 1939 its president, Morris Fishbein, called old-age and unemployment insurance "a definite step toward either Communism or totalitarianism"; in the late '40s, when Harry Truman revived dreams of a national health insurance program, the AMA mounted the most expensive lobbying campaign in history, attacking the Truman-backed Wagner-Murray-Dingell bill as "socialized medicine" and "a threat to free institutions." That bill, which envisioned a Federally sponsored, comprehensive health insurance program for all Americans, had the support in a Gallup poll of 59 per cent of the public. It never reached the floor of Congress.

From their fresh defeat partisans of health reform learned that lobbies often spoke louder than inert citizens. They also discovered that the AMA was no longer alone in its continuing struggle: This time it had been joined by an organization known as the Insurance Economics Society of America—an old, previously lackluster association made suddenly young by the flow of new business to health insurers, and made suddenly zealous by the Wagner-Murray-Dingell bill. The society formed another link in that familiar and ever-lengthening chain of failure: "The lost reform" of 1935 compelled people to buy commercial health insurance, which in turn created a new, anti-health-reform lobby in 1946.

Faced with this new alliance, a

vast discouragement seemed to set in among partisans of national health insurance. No longer did they talk about comprehensive programs for all Americans; instead, bowing to pragmatism, they focused on the two sectors of the populace that stood most in need—the poor and the elderly. It took two decades and a certain amount of luck for the new strategy to pay off; but in 1965, following Lyndon Johnson's landslide election, Congress overwhelmingly passed Medicaid and Medicare. The vote for Medicare was 313-115 in the House and 68-21 in the Senate, despite warnings from the AMA that Federally insured health care for the elderly would be "a cruel hoax and a delusion," and despite an estimated $7 million spent the previous year by AMA's political arm, AMPAC, in support of Congressional candidates pledged to vote against Medicare.

Both new programs were written as amendments to the original Social Security Act (a victory at last for the long-vanished CCMC). Medicaid shared Federal funds with the states in an effort to cover the health costs of all persons considered "medically indigent," but the states were left considerable leeway both in defining the terms and in distributing the funds.

Medicare, by far the broader of the two measures, gave to all persons 65 and over compulsory hospital insurance financed through Social Security (Part A); it also subsidized voluntary insurance for other medical bills (Part B). Benefits under Part A included 90 days of hospital care, 100 days of nursing-home care and hospital out-patient services—all subject to certain "deductibles." Part B, an optional program of additional benefits, covered 80 per cent of "reasonable" doctors' fees, more nursing-home benefits, in-hospital laboratory and diagnostic work, ambulance calls, surgical dressings, and an assortment of other services. The cost of Part B, which carried with it an annual $50 deductible, was to be met by individual payments of $3 per month, with the government contributing matching funds.

The complicated formula—"brewed by adept political alchemists," Rosemary Stevens has noted—was designed to pacify the opposition. By designing a maze of deductibles, benefit time-limits and other special conditions, Congress was inventing a rich new market for private health insurers ready to fill in the Medicare coverage cracks; and by failing to set a national price ceiling on those medical services the government would be subsidizing, other than to state that charges should be "reasonable," Congress was handing physicians and hospitals something very close to a blank check. Prices have been soaring ever since.

It can readily be seen that the new legislation was more sweeping, and perhaps more humane, than any that had come along since Social Security. Yet it fell short of the old dream of universal health insurance kindled by the Bull Moose party, and fanned by the New Deal and Fair Deal. The Great Society's Medicare was half an idea whose time had come. The other half was still cooking in the political crucible.

Withal, and contrary to nearly everyone's expectations, Medicare has been gradually revolutionizing our health care system. Originally based on threadbare assumptions affirming the sanctity of fee-for-service medicine, the program has nonetheless uncovered major flaws in the medical system that cannot safely be ignored. The rickety fee-for-service structure, the inefficiency of many hospitals, the duplication of medical services—these and other weaknesses have been dramatically revealed and underscored by eight years of Medicare. In consequence, Federal pressures have been mounting for such systemic reforms as peer review, hospital planning and cost accounting. Medicare was meant to shore up a sagging health care establishment, but may end by reorganizing it.

In any case, the massive Federal incursion into medicine has forever altered the AMA's role vis-à-vis both its constituency and the larger public. Though it remains a formidable roadblock to reform, its

function is more and more that of an intermediary among conflicting parties: the hospitals, the insurance companies, the specialists, the general practitioners, and the Federal government. It is no accident that AMA leaders last fall pressed the membership to accept a Federal mandate for peer review—not because they liked it but because it was there. AMA officers these days may be bringing a measure of political realism to the redoubtable wonderland of fee-for-service medicine.

To sum up thus far, the status and outlook of American health care and its practitioners have shifted radically over the past century and a half: from superstition and art to art and science; from self-taught freelancer to licensed degree-holder; from generalist to specialist; from solo practice to slowly multiplying forms of group practice and medical corporatism; from fee-for-service billing to experiments with prepayments; from public disdain to public reverence, and now to public doubt; and from classic, laissez-faire capitalism to evolving varieties of Federal subsidy and control. Concurrently, the American Medical Association has proceeded from weakness and altruism to strength and professionalism (dividends of the Flexner Report), then on to blind protectionism in behalf of an increasingly defensive membership, and lately, as in the case of peer review, to timid mediation among contending interest groups.

All of which has left the patient wondering how to survive in a medical world he desperately needs but scarcely understands. The outcome remains in doubt, but it seems safe to say that the doctor's political voice is weaker today than it has been at any time since Theodore Roosevelt, and it is being frequently interrupted by unhappy consumers. Furthermore, the doctor must now reconcile his interests to those of two relatively new political entries, the hospitals and the purveyors of health insurance. Both these institutions have come to play a major role in deciding the costs, availability and quality of health care in America.