Title
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Permalink
https://escholarship.org/uc/item/51x6s155

Author
Wasserberger, Lindsay

Publication Date
2011-05-04

Supplemental Material
https://escholarship.org/uc/item/51x6s155#supplemental
The AMA: Political Player or Pawn?
By: Lindsay Wasserberger

Without their white coats and stethoscopes, the 800 men and women who gathered at the San Diego Marriott in early November for the American Medical Association’s House of Delegates Interim Meeting weren’t obviously doctors. Sporting those little plastic convention name tags (hanging from purple lanyards around their necks), they could easily have passed for members of any other American trade group combining business and pleasure at the conference rate of $160 a night, continental breakfast included. They even had a snappy motto—“Together We Are Stronger.” At first blush, it didn’t seem the least bit ironic.

There are around 814,000 practicing physicians in the United States, and approximately 15 percent of them belong to the AMA. The association’s other members are medical students, residents and retired physicians. But both the federal government and the AMA benefit from a mutually nurtured fiction that the association represents the majority of U.S. doctors and that its position on any given issue represents consensus of the medical profession. In the early days of debate over President Obama’s health care proposals, polling by the Gallup Organization showed Americans trusted doctors many times more than politicians to do what was right for patients. Given the political climate in 2009, the AMA’s decision to support universal health care was critical to congressional Democrats and the Administration in pushing through a final bill.

Similarly, the AMA is bolstered among members and the public by the false perception that its broad reach among practicing doctors and lobbying savvy on Capitol Hill give it serious bargaining power in Washington. In fact, AMA membership rolls have been steadily declining since the mid-1960s. Even counting the entire current membership of 228,150 working or retired physicians and medical students, the AMA represents only about 28 percent of the nation’s doctors. That’s down from 75 percent in 1960. And while the Association spent more than $20 million in 2009 to lobby Congress just on health care reform, its team of 33 lobbyists had little to show for their efforts when the final health care bill was approved.

Perhaps more significant for AMA’s future than membership numbers, however, is a growing internal divide over what the organization should stand for and how it should define its modern mission. Some doctors insist the AMA needs to become more of a trade group to stay relevant. This faction wants an association agenda focusing on what goes on within the walls of a physician’s office – discretion over medical procedures, testing, billing, and the doctor-patient relationship. At its core, this philosophy assumes that only through helping doctors can the AMA and physicians truly benefit patients. Other factions argue the AMA should speak out on a variety of issues like climate change and repeal of the Defense of Marriage Act because these are in fact public health issues, and physicians should be at the forefront of discussions about them.

For three days of mostly civil but occasionally heated debate, the AMA delegates in San Diego weighed in on everything from requiring use of a helmet when skiing (yes, they
finally agreed) and allowing doctors to own hospitals (another aye) to modifying provisions of the new health care law, referred to among this crowd as PPACA (pee-paka), shorthand for the Patient Protection and Affordable Care Act. (Those proposed modifications were tabled for later deliberation by the AMA’s Board of Trustees.)

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A Floor Full of Florida

The Florida Medical Association considered not sending any delegates to the San Diego meeting as a sign of its complete lack of faith in AMA leadership. Instead, on September 7, 2010, the president of the FMA, Madelyn Butler, sent a letter on the FMA’s behalf to Dr. Ardis Hoven, the chair of the AMA Board of Trustees. It declared that the delegation had lost confidence in the AMA’s ability to “protect the medical profession” and went on to say that members of the Florida association feel “the AMA needs to change its direction and become more focused on advocating for practicing physicians’ interests.”

Translation: Butler and her group were furious and frustrated that the AMA’s governing body had given the White House a major political victory with the endorsement of universal health care and failed to achieve much in return. The legislation Congress ultimately approved contained neither a new formula for reimbursing doctors who treat Medicare patients, nor limits on medical malpractice liability. Both are long standing AMA positions. Worse yet, Florida Medical Association officials argued, AMA leaders failed to eliminate provisions the organization did not want, including an unfunded requirement that doctors adopt an electronic record system (estimated to cost something like $40,000 a system). After 164 years of fighting universal healthcare, the AMA supported the House bill loathed by congressional Republicans to have a place at the bargaining table only to leave other AMA priorities vulnerable to the new, GOP-controlled House of Representatives.

Under the circumstances, AMA President Cecil Wilson, himself a Floridian, aimed for the high road. The delegates before him in the purple and white Marriott ballroom were seated by state, as they are in political conventions, and he spoke to them like a candidate, like a general rallying his troops before battle. As he reiterated the AMA’s commitment to what it describes as Medicare payment reform, he allowed himself one small bow to reality: “Ultimately, there is no guarantee that Congress will act – or if they do that it won’t disrupt physician practices,” Wilson said, moving quickly along to stories about sailing crews and prisoners of war, exhorting the delegates to stick together. “The surest path to failure is to succumb to those who sow dissent – who would have us submit – divided, and conquered,” he said. “If we resist division, we can move medicine forward to a better place. This is our path. This is our quest. This is our charge.” The delegates gave him a standing ovation.

Florida was having none of it. Its delegates were among the most vocal at the San Diego meeting. First, during the opening day open forum, and then later through submission of a formal resolution, they argued that the AMA should amend its 164-year-old mission
statement, which seeks “to promote the art and science of medicine and the betterment of public health” to add “helping physicians practice medicine.” Florida didn’t just want the statement changed on paper and filed away; its members wanted the change communicated to people both inside and outside of the AMA as soon as possible.

Florida delegate David McKalip was passionate on the subject. “I want to see an AMA with a willingness to disagree publicly with government and not just with things easy to disagree with like the SGR,” he said, referring to the Sustainable Growth Rate, the Byzantine accounting formula by which the federal government determines how much doctors will be reimbursed for Medicare patient services. Last year he resigned as president-elect of the Pinellas County Medical Association in Florida after, as a commentary on health care reform, he forwarded a photo of President Obama as a witch doctor to his Tea Party listserv. McKalip had laid low until recently.

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Seeming to neglect physicians’ concerns threatens the AMA’s standing among doctors, while inadequately addressing patient needs hurts its public perception. The AMA is valuable to the federal government because doctors are more credible with the public than politicians. But without doctors, the AMA is valueless. The AMA needs the support of both constituencies to maintain its political leverage. So who comes first?

The convention delegates spent a great deal of their time in San Diego pondering this almost existential question, including a final session where, at one point, a single word seemed to hold the answer to the association’s identity. For more than a decade, the AMA has argued that doctors who refuse to accept Medicare reimbursement rates as payment in full for their services should be allowed to treat Medicare patients anyway and simply charge them the difference between the Medicare payment and their own fees. The AMA used to call its proposal “balanced billing” but recently decided that “private contracting” had a better ring with consumers. The proposal has been introduced in the House as the Medicare Patient Empowerment Act. But, delegates debated, should it be a priority or a “top priority” for AMA’s lobbying team?

“It serves the good of returning some control to the patients and their doctors, and we need it to be a top priority,” a Kansas delegate said emphatically.

A delegate from New York heartily agreed. “We very much favor this for the protection of our Medicare patients, which I would remind everyone we will all be if we live that long.”

A delegate from Massachusetts who wanted no part of the adjective pleaded with his colleagues in frustration, “For it to be a top priority, we have to decide whether we are a professional organization or a trade organization and how that would appear to the public.”

AMA HISTORY SIDEBAR
The American Medical Association is the nation’s oldest and largest physician organization. It was founded in 1847, initially to improve and standardize medical education. But it has always served two functions: improving medical care and protecting the financial interests of physicians. By making the profession’s barriers to entry tougher, the AMA intertwined its two goals; fewer physicians at a time when competition for patients was fierce, meant greater pay. Indeed, the AMA’s first Code of Ethics outlined both physicians’ duties to the public—foremost to provide quality care—and physicians’ rights, including being adequately paid.

Nathan Davis, a 29-year-old doctor from New York, is generally credited with the founding of the AMA. His original goal was to require more rigorous medical education in the state, but he correctly reasoned that without a national education standard, doctors could simply move to other states. The profession wasn’t yet prestigious, physicians were also called “pill peddlers,” and medications were unmonitored. The industrial and scientific revolutions were just beginning, and science-based medicine wasn’t yet the dominant form of healthcare.

The association stagnated for its first 50 years. Its membership, according to historian James Burrow, hovered around 10 percent of the 100,000 qualifying practitioners, who often chose to only belong to their state’s medical society and it excluded homeopaths, osteopaths, and alchemists, as well as African-Americans on the premise the latter had lower educational standards. Unable to convince the federal government to take on a greater regulatory role in medicine, the AMA was forced to do so itself.

In 1901, the organization launched a complete structural overhaul, integrating state and county societies, thereby boosting its membership. By 1908, the AMA had 70,000 members. During this time, the association expanded its Committee on Medical Legislation, which forged relationships with politicians. As Burrow notes, “The Association hoped to add greater credibility to the position that it spoke for organized medicine.”

Since the AMA performed regulatory functions—and established its own laboratory—it became a valuable government resource. In 1905, the AMA House of Delegates resolved that its Board of Trustees ask the U.S. Secretary of Agriculture that the federal Bureau of Chemistry to work with the AMA Council on Pharmacy and Chemistry, which tested medications. Secretary James Wilson responded, “It seems to me that the collaboration with the great body of American physicians who form the American Medical Association affords a splendid opportunity to carry out the work which Congress intends to be done.” With those words, the AMA and U.S. government became partners and the AMA gained international notoriety.

By this time, the Progressive Movement, which sought reforms to end waste and corruption, was underway and the association’s early successes, such as exposing fraudulent medication, embodied the progressive values popular with the public. The AMA contributed to the passing of the Pure Food and Drugs Act. In 1910, the
organization published the Flexner Report, which investigated and reported the poor conditions of medical schooling. The AMA served a critical role in the formation of government medical infrastructure, advocating for the collection of vital statistics and the creation of a federal Department of Health with cabinet status.

But after World War I, its successes switched from ones that enabled the government to ones that hampered it, particularly the push for national health insurance. The AMA defeated both its inclusion in the 1935 Social Security Act and President Truman’s campaign for national health insurance during the late 1940s and early 50s. A New York Times article from 1952 called the AMA “the most powerful lobby in the country.”

But actually, the AMA only succeeded in delaying compulsory insurance by acquiescing to voluntary insurance. Once opposed to insurance in any form, the association launched a multimillion-dollar public relations campaign with the slogans: “Compulsory health insurance is political medicine,” and “The voluntary way is the American way.”

Earlier, the AMA had experienced total defeats. In 1921, the government passed the Sheppard-Towner Act, which provided federal funding for maternity and child care, despite AMA opposition; the association, which coined the term “socialized medicine” while fighting against national health care, thought the bill took a step toward socialism. In 1933, the AMA said the U.S. Emergency Relief Administration was “a complete and undisguised example of ‘state medicine’.”

But its most significant failure came in 1965 with the passage of Medicare, which it vehemently opposed. “Politically the AMA lost the pennant,” the Saturday Evening Post’s story on the passage quoted a congressional aid as saying. “It used to scare the hell out of Congress. But the docs yelled socialism once too often, and Congress quit listening to them.”

Instead of fighting back, the AMA worked to maximize physician payment under Medicare. It created a standardized procedural coding system that doctors could use to bill the government. When it described the numerical system, Current Procedural Terminology (CPT), in its professional journal in 1970, it closed the article with a quote from William Shakespeare’s Tempest: “Mind your speech, lest it mar your fortune.” The quote became apropos when the federal government incorporated the AMA’s copy written system into the governmental billing structure in 1996, giving the AMA control over how Medicare dollars are disbursed. Again, the AMA became intimately involved with national medical infrastructure.