ANNALS OF MEDICINE

INSIDE THE AMERICAN MEDICAL ASSOCIATION'S FIGHT OVER SINGLE-PAYER HEALTH CARE

A long-standing battle highlights a profession's political transformation.

By Clifford Marks

February 22, 2022

Illustration by Nicholas Konrad / The New Yorker

Joy Lee and Dan Pfeifle arrived early for the June, 2019, meeting of the American Medical Association, where they were helping to lead a gathering of the A.M.A's medical-student delegation. The medical students usually assembled early to discuss

priorities, but this year they had an additional reason to strategize: they had decided that they would try to persuade the A.M.A.'s governing body, the House of Delegates, to end the organization's explicit, long-standing opposition to single-payer health care. They had just a few days to line up the votes.

A.M.A. meetings are like political conventions. Doctors are part of region- or specialty-based delegations, which host receptions and happy hours. In conference rooms and over drinks, Lee, Pfeifle, and dozens of their colleagues buttonholed delegates, hoping to build support for their measure, which would rescind the organization's stated policies opposing the idea of health-care reform built around a single-payer system. Some delegations—New England, the Pacific states—were reliably progressive, and many people at those events supported single-payer. But conversations elsewhere weren't so encouraging. "I already felt almost defeated," Devin Bageac, a medical student at the University of Connecticut who helped with the lobbying efforts, told me. For decades, the largest association of American doctors had also been one of the country's most effective opponents of progressive health-care reform; for much of its history, persuading the A.M.A. to consider a single-payer-style system was a little like asking today's National Rifle Association to support a ban on assault weapons.

On the day of the vote, the House of Delegates met in a cavernous ballroom. More than six hundred people were in attendance. As measures were introduced, delegates streamed to the microphones to debate them. A.M.A. meetings are contentious—the organization has had to use pressure sensors to track the order in which speakers get in line—and this one proved no different. Many delegates from higher-paying medical specialties and conservative state medical societies opposed the measure. Donald Palmisano, a former A.M.A. president, reportedly said that the association "ought to put a stake in the heart of single-payer." To allow delegates to vote for their measure without facing backlash, proponents had asked for a tallied, private vote, without verbal "aye"s and "no"s. After a long pause, a large screen in the front of the hall displayed the result: "aye"s, forty-seven per cent; "no"s, fifty-three per cent. The measure had failed by just thirty-eight votes.

"I kid you not, there was an audible gasp in the room," Sophia Spadafore, who at the time was a team leader in the medical-student section's caucus, recalled. "All these delegates we had never met were coming up to us after, saying, 'You're doing it, you'll get it next time, keep going, we support you.' " Much to their surprise, the students had come close to staging a revolution in American medicine.

The A.M.A. is rooted in a version of the medical profession that's unrecognizable today. When the organization was founded, in the eighteen-forties, its chief aim was to raise professional standards. As the Princeton sociologist Paul Starr writes in his book "The Social Transformation of American Medicine," the profession was nearly unregulated, and medical schools proliferated regardless of the quality of their instruction; a year of coursework would typically contain three to four months of actual learning, and although two years were required for a medical degree the second was often just a repeat of the first. A doctor with a state license could practice even if he lacked a medical-school degree, and state medical societies, hungry for licensing fees, insured that requirements were lax. The profession's low barriers to entry produced a glut of providers, which drove down wages. Unable to find work near their schools or home towns, new doctors struck out for rural or frontier areas. Competition grew in even these remote places.

The A.M.A. gained control over education and licensure. By the turn of the twentieth century, reformers had codified new requirements for medical schools, and the number of schools plummeted, along with the number of new doctors. In 1901, the A.M.A. became a confederation of state societies; over the next decade, Starr writes, the number of A.M.A. members increased

nearly tenfold. More than half of American physicians soon joined. State and local medical societies accumulated political power and financial clout, and new perks of membership—including defense from malpractice claims—drove a further rise in enrollment.

In the same period, new understandings of disease and human physiology combined with more rigorous training to improve the practice of medicine. This built a respect for the profession which, in turn, helped spur attempts to create a publicly financed health-care system. Progressives introduced such legislation at the state and national levels, and, in June, 1917, the A.M.A. endorsed compulsory health insurance. But it quickly faced a revolt from the state societies, whose members feared a drop in wages, and reversed course. That same year, a California referendum proposed the establishment of a state-run health-insurance system, but a group of California physicians, the League for the Conservation of Public Health, launched an opposition campaign based on fears of German infiltration. "What is Compulsory Social Health Insurance?" one pamphlet read. "It is a dangerous device, invented in Germany, announced by the German Emperor from the throne the same year he started plotting and preparing to conquer the world." The measure was overwhelmingly defeated.

This set the tone. In 1932, an editorial in the *Journal of the American Medical Society* denounced a proposal for government-backed voluntary health insurance as "an incitement to revolution"; three decades later, in response to a different proposal, the A.M.A. produced "Ronald Reagan Speaks Out Against Socialized Medicine," an LP on which the future President warned listeners that they would spend their "sunset years" telling their grandchildren "what it once was like in America when men were free." Starr told me that physicians "had a lot of cultural authority," and weren't shy about using their community contacts to shift public opinion. In 1949, Gallup found that fifty-nine per cent of Americans supported Harry Truman's plan for a payroll-tax-financed, government-run insurance system; the A.M.A. charged each member an extra twenty-five dollars to finance a lobbying campaign, and by its end support for the proposal had fallen to twenty-four per cent. In his memoirs, Truman wrote that his defeat at the hands of the A.M.A. troubled him more than any other in his Presidency. "There are a lot of people in Congress who jump when the American Medical Association cracks the whip," he once said.

The postwar period marked the apogee of the A.M.A.'s political power. The country began changing in the sixties and seventies, and the medical profession changed with it. Feminism and Title IX combined to open medicine to women, who made up nine per cent of medical students in 1970 and more than twenty-five per cent by the end of the decade. Civil-rights and immigration legislation had similar consequences for people of color. Because postwar medical schools produced so few doctors, residency programs turned to graduates of international medical schools to fill the gap; this coincided with the elimination of country-based quotas that limited emigration from outside northern and Western Europe. Large numbers of new physicians hailed from India, Pakistan, South Korea, or the Philippines; many now serve as primary-care doctors in impoverished and rural communities that have a hard time attracting U.S. graduates. Today, a quarter of practicing American physicians have graduated from medical schools abroad. Around half of American medical students are female, and around half are nonwhite.

The financial picture for physicians has changed, too. The prototypical twentieth-century doctor was a small-business owner, but increasing medical complexity, specialization, and regulatory requirements have made this less common; today's physician is more likely to be an employee than an employer. Many younger doctors emerge from medical school with hundreds of thousands of dollars in student debt, and fewer than half of American doctors own their own practices. Physicians used to be able to name their prices, but now have to deal with pre-authorization requirements, denials of coverage, and drug costs for some patients that can run into the millions—challenges to which a public-sector alternative might seem preferable.

In the early nineteen-nineties, the Clinton Administration sought the A.M.A.'s support for its health-care initiative. Hillary Clinton flew to Chicago to speak at its annual meeting; her speech was greeted with a mix of warmth and wariness. Some smaller organizations backed the plan, some opposed it, and the A.M.A. largely sat out the fight. A decade and a half later, the A.M.A. signalled its support for many of the Obama Administration's health-care proposals, including individual mandates for health insurance, before backing the whole package. At the last minute, a bloc of conservative physicians succeeded in passing a measure rescinding A.M.A. support for the individual mandate; leadership prevented the proposal from taking effect by tabling it until the next meeting. Organized medicine had become a house divided. A 2016 poll found that thirty-five per cent of doctors consider themselves Democrats, whereas twenty-seven per cent identify as Republicans; fifty-six per cent support single-payer health care.

Hilary Fairbrother, an emergency-medicine physician and former chair of the A.M.A.'s Young Physicians Section, told me that, in the early two-thousands, when she joined the A.M.A., it had been focussed on "pocketbook issues." "That was never going to be enough for my generation," she said. "It's certainly not enough for millennials or Generation Z." In the last few years, the A.M.A. has expanded its focus. It declared gun violence a public-health crisis, opposed the Pentagon's ban on transgender troops in the military, and joined in filing a brief with the Supreme Court opposing the Trump Administration's decision to end the Deferred Action for Childhood Arrivals program. "I think a lot more individuals are going into medicine with more of a social-justice bent," Anna Yap, an A.M.A. delegate and resident physician at the University of California, Los Angeles, said. "We're trying to have more first-generation doctors come into medicine, more people of color. . . . I think that, because of that change in our workforce, we're seeing changes in what we're interested in pushing for."

The A.M.A., and physicians generally, are no longer the most dominant force in health politics. Many of the most consequential negotiations over the Affordable Care Act involved the pharmaceutical, hospital, and insurance industries, which command formidable lobbying operations; the rise of these other power centers is yet another explanation for the profession's new openness to greater government involvement. But, even if its influence is reduced, the prospect of the A.M.A. moving toward the single-payer camp remains tantalizing for progressives. Since 1998, the A.M.A. has spent four hundred and sixty-two million dollars on lobbying, an amount exceeded only by the expenditures of the U.S. Chamber of Commerce, the National Association of Realtors, and the American Hospital Association. And, as single-payer proponents in decades past discovered to their chagrin, physicians can exert a broader influence. "There's a cultural authority there," Jacob Hacker, a professor of political science at Yale, told me. "If physicians are really on the side of a much more just health-care system, I think that can move the needle."

What physicians do with their cultural authority is being debated both within medicine and outside of it. In October, the A.M.A. and the Association of American Medical Colleges Center for Health Justice jointly published a pamphlet titled "Advancing Health Equity: A Guide to Language, Narrative and Concepts." The guide urges a series of word-choice changes ("historically marginalized" instead of "minority," "oppressed" rather than "vulnerable"), and also a reframing of the ways physicians explain and understand problems of health inequity. The pamphlet asks readers to evaluate an already-progressive sentence: "For too many, prospects for good health are limited by where people live, how much money they make, or discrimination they face." It suggests an alternative: "Decisions by landowners and large corporations, increasingly centralizing political and financial power wielded by a few, limit prospects for good health and well-being for many groups."

The New York *Post* and Fox News immediately tagged the effort as another example of critical race theory run amok. Other commentators questioned whether the pamphlet was the best use of physicians' cultural capital, or wondered how seriously to take

the organization's rhetoric given its long history of standing against reforms that threatened to reduce physicians' earning potential. The profession stands at a crossroads—between a burgeoning progressivism driven in part by newfound diversity, on the one hand, and its age-old desire for greater economic security, on the other.

MORE SCIENCE AND TECHNOLOGY

- The couple who failed to launder billions of dollars in stolen bitcoin.
- Can you warm yourself with your mind?
- A new story for Stonehenge.
- The trouble with Spotify (not involving Joe Rogan).
- What comes after the COVID booster shot.
- Why Texas's power grid still hasn't been fixed, despite deadly failures.

Sign up for our daily newsletter to receive the best stories from *The New Yorker*.

Clifford Marks is an emergency-medicine resident at the Icahn School of Medicine at Mount Sinai.

More: American Medical Association Health Care Health-care Reform Single Payer Health Insurance

THE DAILY

The best of *The New Yorker*, every day, in your in-box, plus occasional alerts when we publish major stories.

E-mail address

Your e-mail address

Sign up

By signing up, you agree to our User Agreement and Privacy Policy & Cookie Statement.

Do Not Sell My Personal Info