

PUBLIC STATUTES, PRIVATE CODES: ORGANIZED LABOR, ORGANIZED
MEDICINE, AND THE REGULATION OF CONTRACT MEDICINE IN OREGON,
1906-1952

by

DONALD ROBERT STEVENS

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Daniel Pope, Chair of the Examining/Committee

June 1, 2010
Date

Committee in Charge: Dr. Daniel Pope, Chair
 Dr. Glenn May
 Dr. James Mohr

Accepted by:

Dean of the Graduate School

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Between the early 1900s and the 1952 U.S. Supreme Court case of *United States v. Oregon State Medical Society*, conflicts over the legality and permissibility of contract medicine raged in Oregon. Organized labor opposed the practice because it restricted their choice of physician, and because they resented mandatory wage deductions to pay for the contracts. Organized medicine resented contract medicine for its imposition of commercial power on physicians. The groups initially attempted to resolve the issue publicly through legislation, but procedural factors and a lack of group cohesiveness prevented a public solution. Beginning in the 1930s, the State Medical Society imposed its own private code of ethics on the medical services market to eliminate contract practice, and used the legislative process to preserve its independence to pursue a private sector solution. Ultimately, the Supreme Court

allowed this approach, based partly on its view that medicine was distinct from business.

CURRICULUM VITAE

NAME OF AUTHOR: Donald Robert Stevens

PLACE OF BIRTH: Portland, Oregon

DATE OF BIRTH: December 21, 1984

GRADUATE AND UNDERGRADUATE SCHOOLS ATTENDED:

University of Oregon, Eugene, Oregon
Stanford University, Stanford, California

DEGREES AWARDED:

Master of Arts, History, 2010, University of Oregon
Bachelor of Science, Chemistry, 2007, Stanford University

AREAS OF SPECIAL INTEREST:

United States History
American Legal History

PROFESSIONAL EXPERIENCE:

Information Security Intern, City of Portland, 2008

Business Operations Intern, City of Portland, 2007-2008

GRANTS, AWARDS AND HONORS:

Oregon Heritage Fellowship, "The Private Market Solution: The Oregon State Medical Society Confronts Contract Medicine in the 1930s," Oregon Heritage Commission, 2010

Robert C. Byrd Honors Scholarship, U.S. Department of Education, 2003

PUBLICATIONS:

Donald Stevens, Mark Trinh, and Julia Swanson, "In Vitro Evaluation of Methods for the Determination of Left Ventricular Flow Propagation Velocity," *Circulation*, Vol. 108, No. 17, 2003, p. IV-393.

Donald Stevens, Mark Trinh, Aarti Hejmadi, X. Li, David J Sahn, "In Vitro Study of Flow Propagation Velocity as it Relates to Stroke Volume and Heart Rate," *Journal of the American College of Cardiology*, Vol. 41, No. 6, 2003, p. 419A.

Hassan Ghani, Donald Stevens, Jacqueline Weiss, Richard Rosenbaum, "Vitamins and the Risk for Parkinson's Disease." *Neurology*, Vol. 59, No. 8, 2002, pp. E8-9.

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I proudly dedicate this work to my granddad, Rodney David Stevens, Sr., 1920-2006.

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CHAPTER I

INTRODUCTION

On October 28, 1921 the Oregon Supreme Court handed down the first in a pair of cases which touched on the degree of discretion patients had in making medical decisions for themselves under Oregon's workmen's compensation laws. Conrad Grant, the plaintiff in the case, worked as a riveter for the Columbia River Shipbuilding Company. In the course of performing his occupational duties, Grant slipped, struck his knee against a piece of steel, and threw it out. After several months of treatment, Grant's knee was no better: approximately twice per month, a piece of cartilage slipped out, and his knee became swollen and locked. During these times, Grant was unable to work, and the State Industrial Accident Commission (SIAC) was compelled to make disability payments to cover his lost time at work.

Under a 1917 act of legislature, SIAC was authorized to compel its patients to undergo "medical or surgical treatment as the Commission deems reasonably essential to promote his recovery..."¹ Using its powers under this act, the commission and its physicians attempted to force Grant to undergo a tricky operation to sew the cartilage into place. Worried about the surgery's outcome, Grant sued the commission. On appeal, the Oregon Supreme Court sided with Grant, constructing the 1917 statute broadly to hold that the commission's physicians' advice was only advisory in the context of potentially-dangerous operations. The trial court jury had the power to determine the reasonableness

¹ Oregon. House. *House Bill No. 408*. Twenty-Ninth Legislative Session, 1917.

of SIAC's decisions, as it had when it decided the case in Grant's favor prior to appeal by the commission.²

Less than one year later, the court delivered its ruling in the second case of the pair. The plaintiff in this second case, logger Wincent [sic] Smith, suffered several injuries when a log fell on his head and shoulder, cut his head, sprained his shoulder, and bruised his right foot.³ According to his physician, Coos County contract physician George E. Dix, Smith was a "rather irritable patient."⁴ The patient constantly disobeyed Dix's orders, periodically removed his bandages, and when he determined that his condition had not improved, left the hospital against without Dix's permission. After leaving the hospital, Smith traveled to Portland and underwent a shoulder operation performed by Dr. Samuel Slocum.

As a worker covered under the industrial accident system, Smith believed that SIAC would cover his medical and surgical bills. The commission disagreed: Smith was covered under a contract between his employer, the Smith-Powers Logging Company, and Dr. George E. Dix. By the terms of that contract, Smith was required to obtain his medical care exclusively from Dr. Dix. Smith's attorney, Harry G. Hoy, attempted to sway the case in Smith's favor using the recently-established precedent from Grant's case.

² Oregon. Supreme Court. Oregon Reports. *Grant v. State Industrial Accident Commission*.

³ Oregon. Supreme Court. 563 Oregon Briefs. *Smith v. State Industrial Accident Commission*, Appellant's Abstract of Record, p. 6.

⁴ Circuit Court of the State of Oregon for the County of Multnomah. *Wincent Smith v. State Industrial Accident Commission*. Oral Testimony. Document H-6152, Jan. 20, 1922, p. 37. Oregon State Archives.

When Smith's case came before the court, the judges sided with SIAC: under the workmen's compensation statutes, the commission had the authority to designate Smith's physician.⁵ The reasonableness precedent from Grant's case applied merely to refusal of certain types of treatment, and not to the selection of a physician.

The focus on the patient's discretion in medical decision-making under the workmen's compensation system in both the Smith and Grant cases was probably no accident. The two cases occurred in the context of heated legislative battles over the regulation of contract medicine and hospital associations. The main factor behind Smith's loss was his coverage under this company's medical service contract with Dr. Dix. At the time of his injury, and for more than two decades beyond, those state workers who fell under the workmen's compensation statutes were covered under two different types of plans. The majority of the workers received their care from an open panel of commission-approved physicians. An injured worker could choose to visit any of these doctors, and the doctor would remit the bill to the commission. Approximately forty percent of workers, however, received their care through medical service contracts

⁵ This is a slightly troublesome point in the court's reasoning. Technically, the Smith-Powers logging company made the contract with Dr. George Dix. Thus, the commission's contract with Dr. Dix was only by proxy. Testimony by C.C. Bechtold before the Legislative Workmen's Compensation Committee of the State of Oregon in 1926 criticized the State Industrial Accident Commission for its proposal that it be permitted to enter directly into medical service contracts with individual doctors and hospital associations. If SIAC contracted with Dr. Dix, it was only by proxy through the Smith-Powers Logging Company. *See: Oregon. Legislative Workmen's Compensation Committee of the State of Oregon. Report of the Legislative Workmen's Compensation Committee of the State of Oregon, 1927, Oregon State Archives.*

according to Industrial Accident Commissioner William Kirk.⁶ These contracts were formed between the employer and either a single doctor or group of doctors, or a hospital association. Under Oregon's statutes, these workers were restricted to this closed panel-type system; they were not permitted to choose their physicians as the other sixty percent of workers did.⁷

Factual and Historical Background

Sociologist and leading medical historian Paul Starr described three factors that caused employers to sign medical service contracts. First, physicians were generally unavailable in the isolated areas which were home to railroad, mining, and lumber camps. A contract with a physician or hospital association ensured that medical service would be available when needed. Second, employers sought to limit their legal liability by providing medical protection. Finally, medical service contracts were intimately tied in with welfare capitalism.⁸ The provision of medical service aided employers in spinning

⁶ Circuit Court of the State of Oregon for the County of Multnomah. *Wincent Smith v. State Industrial Accident Commission*. Oral Testimony. Document H-6152. Jan 20, 1922, p. 66.

⁷ Open panel plans allow patients to visit any licensed physician. In a closed panel plan, the patient may only see those physicians with whom the insurer has contracted. *See also*: Oregon. State Industrial Accident Commission. *Work Accidents in Oregon*, (Salem: [no publisher information], 1923; Pierce Williams, *The Purchase of Medical Care Through Fixed Period Payment* (National Bureau of Economic Research, 1932), pp. 77-78. Online. Accessed 04/27/10. <http://www.nber.org/books/will32-1>.

⁸ Lizabeth Cohen supplements Starr's account nicely in her case study of industrial workers in Chicago. Welfare capitalism, she argued, achieved several goals. Introducing ethnicity into her analysis, she showed that welfare capitalism served the important function of "breaking up ethnic communities in the factory." In this manner, the welfare

“an elaborate web of affiliations binding them to their companies,” in addition to promoting Americanization of foreign workers. “Medical care,” Starr wrote, “functioned as an element in this strategy of control.”⁹

Medical service contracts were usually paid for by employee contributions. Some plans operated on per diem contributions, but the vast majority of plans seem to have required workers to pay a fixed fee on a monthly basis, usually between \$1.00 and \$1.50. The employer took responsibility for collecting the fees and forwarding them on to the contract doctor or hospital association.¹⁰ In exchange, the doctor or hospital association would agree to provide care for a class of medical needs. The contracts usually differentiated between occupational injuries, and occupational and non-occupational illnesses. To cover the latter, employers usually levied a surcharge. Health care providers under the original medical service plans were usually single doctors or small groups of physicians. Eventually, however, these medical service plans came under the control of laymen, who subcontracted out for physician labor.

capitalists attempted to promote better relations with individual employers – relations that would only have been stymied by peer loyalty among workers. In a point more relevant to the present study, Cohen remarked, “Progressive employers advocated providing for the welfare of their own workers and communities to keep the state at bay.” Welfare capitalism, including plans like those offered by the hospital associations, promised to restrain state expansion. *See: Lizabeth Cohen, Making a New Deal: Industrial Workers in Chicago, 1919-1939.* (Cambridge: Cambridge University Press, 1990), pp. 167, 174, 181.

⁹ Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

¹⁰ Pierce Williams, *The Purchase of Medical Care Through Fixed Periodic Payment* (National Bureau of Economic Research, 1932), pp. 77-81. Online. Accessed 04/28/10, <http://www.nber.org/books/will32-1>.

The National Hospital Association rapidly became the dominant hospital association. Originally established in 1906, NHA initially wrote contracts only for individuals. Beginning in 1909, the association expanded to offer group coverage for employers.¹¹ At the time that the Oregon Supreme Court considered the *Smith and Grant* cases, NHA could claim approximately eighty percent of total hospital association revenues within the state.¹² As a lay-controlled group, the National Hospital Association grew to have great influence in the Oregon legislature and the Insurance Commission.

The original medical service contracts were made before coverage for occupational injuries would become widespread under the workmen's compensation system. Oregon followed a national trend when voters approved the Workmen's Compensation Act on referendum from the Oregon legislature on November 4, 1913 by a vote of 67,814 to 28,608.¹³ The legislation was originally drafted by a commission of nine men appointed by Governor Oswald West in 1912. West selected three men each to represent labor, capital, and the state's taxpayers. The commission's report to the governor described the conditions affecting the three groups that it represented. An injured worker's only recourse when he suffered an industrial injury was through the tort

¹¹ "History." Oregon Historical Society Research Library, Farwest American Assurance Records, Mss 2863, Box 1 of 8, Folder 1.

¹² Oregon. Insurance Department. *Report of the Insurance Commissioner for the Year Ending December 31, 1921* (Salem: State Printing Department, 1922).

¹³ The State of New York passed the nation's first workmen's compensation statute in 1910. Mississippi was the last state to adopt a compensation law when it did so in 1948. For information on Oregon's workmen's compensation vote, see: Oregon. Secretary of State. *Blue Book and Official Directory*. (Salem: State Printing Department, 1915), p. 145.

system. Here, he faced complex processes, uncertain results, and bitter outcomes. If he did win, he paid court fees out of his recovery, and was then forced to split the remainder a contingency fee-hungry attorney. Employers, too, faced an unenviable situation: they endured protracted, costly litigation. Such litigation threatened to ruin small-scale producers. The tort situation also harmed the taxpayer – an “innocent bystander,” as the commission described him. The taxpayer bore the “whole burden of expense incident to maintaining the machinery of the courts.” When a workman failed to recover damages, the taxpayer often covered the expense of supporting him. Even when the workman won a substantial recovery, “inexperience or improvidence soon [left] him destitute and without means of support.” These workmen inevitably turned to crime, the commission claimed, and the taxpayers paid for the jails and penitentiaries used to discipline them.¹⁴

The commission’s workmen’s compensation proposal represented a compromise among the three groups.¹⁵ Under the new system, an administrative agency took over the role of the court, collected contributions to a workmen’s compensation fund from employers and employees (the employers accounted for the greater share of the contributions), and dispensed those funds to injured workmen on the basis of well-defined schedules. The award was small, but certain. Any injury sustained “in and of the course of employment” was compensable, even when the victim contributed to the accident through his own negligence. Employers, too, stood to benefit: the system

¹⁴ Oregon. State Industrial Accident Commission. *Report of the Commission Appointed by Governor West to Draft a Compensation Bill*. (Salem: State Printing Department, 1914), pp.27-28. Online. Accessed 03/09/09. <http://books.google.com>.

¹⁵ For additional information on workmen’s compensation historiography, see Appendix A.

stabilized the costs associated with occupational injuries. True, the employer was required to make regular payments, but he no longer faced high legal fees and the occasional large verdict that upset his balance sheets. The third party, the taxpayer, made a concession as well: the legislature was to appropriate approximately one-eighth of the monies collected annually for the State Industrial Accident Fund. The drafting commission argued that, in exchange for this concession, the taxpayer would directly benefit from reduced court costs, and indirectly benefit from the reduction in crime previously committed by destitute, injured workmen.¹⁶

The workmen's compensation dramatically altered the market for medical services, but it did not immediately end competing solutions to the industrial accident problem. Long after 1913, for example, bills introduced in the Oregon legislature specifically exempted lodge practice.¹⁷ This type of practice, operated by fraternal benefit societies, served as one of the original protections against the effects of workplace injuries. The hospital associations, too, refused to be pushed out by the new system, and quickly adapted to the new conditions. Just shortly following the voters' approval of the

¹⁶ Oregon. State Industrial Accident Commission. *Report of the Commission Appointed by Governor West to Draft a Compensation Bill*, p. 31. See also: Lawrence Friedman and Jack Ladinsky, "Social Change and the Law of Industrial Accidents." Friedman and Ladinsky identify only two parties to the compromise: capital and labor. The West Commission's report strongly suggests that workmen's compensation should be regarded as a three-way compromise. The addition of the taxpayer to the existing interpretation is particularly crucial, especially because debates over state funding had the potential to restrict compensation benefits.

¹⁷ See, for example: Oregon. House. *House Bill No. 287*. Thirtieth Legislative Assembly, 1919. This bill exempted fraternal benefit societies from regulations imposed on the proprietary hospital associations.

Oregon workmen's compensation system, NHA General Manager C.C. Bechtold circularized potential clients with a solicitation letter. Workmen's compensation was in its infancy, Bechtold pointed out, and companies could keep costs lower through a medical service contract instead of payments directly to SIAC. Furthermore, NHA's plan offered valuable service beyond what the commission could offer: "This plan of service," NHA wrote, "perfectly supplements and fits in with WORKMEN'S COMPENSATION LAWS and provide a much better protection to the workmen..."¹⁸ Workmen's compensation hardly replaced the hospital associations: NHA and the other associations adapted to the new system, and actually tried to use it to increase annual revenues.

At the same time as hospital association contracts gained popular with companies, they generated ill will among both organized labor and medicine. Opinion in these groups was hardly uniform, but where it was expressed, it was usually negative. The Portland City and County Medical Society, for example, attempted to pass a resolution concerning contract practice in 1906. The resolution specifically condemned contracts made between physicians and associations or corporations like NHA, and also lodge practice. It exempted contracts between individual physicians and companies however, and contained no enforcement mechanism. The resolution ultimately bogged down when society member Dr. G.S. Whiteside pointed out that the society represented only half of 300 physicians in Portland. Without an overriding majority of Portland's physicians in

¹⁸ C.C. Bechtold, "First Aid to the Injured," [no date – probably 1914], Oregon Historical Society Research Library, Accession # Mss 2863, vol. 11 1909-1920, page 34.

support of the resolution, it would have no legitimacy, and even more importantly, no weight.¹⁹

The Oregon State Federation of Labor made its stance much clearer. At the federation's January, 1909 convention in Salem, for example, Delegate J.F Cassidy complained about the assessment of fees by employers to pay for the medical service contracts. The employers, Cassidy complained, would not assist while employees were expected to "go down into their own pockets" to pay for surgical and medical expenses.²⁰ As early as 1914, the State Federation of Labor indicated its support of legislation imposing restrictions on the collection of hospital association fees.²¹

The antagonism of organized medicine and labor toward contract medicine and the hospital associations, initially half-hearted or not, raises important questions. What types of strategies did the Oregon State Medical Society and the Oregon State Federation of Labor employ against contract doctors and hospital associations? To what extent were these strategies successful? Why did the strategies succeed or fail? Did the strategies

¹⁹ "Medical Societies: Portland City and County Medical Society," *Medical Sentinel*. Vol. XIV, No. 4, April, 1906, pp. 174-176. For the leading account of medical ethical objections to contract practice, see: Donald E. Konold, *A History of American Medical Ethics, 1847-1912* (New York: Book Craftsmen Associates, 1962), pp. 68-75. Konold treats the medical profession's ethics in the 1920s and 1930s as fairly steady and consistent, yet provides only a cursory analysis of medical ethics in this period. The instant paper attempts to fill in the gaps for the 1930s. See: chapter 3.

²⁰ Oregon State Federation of Labor. *Proceedings of the Sixth Annual Convention of the Oregon State Federation of Labor* (Portland: Multnomah Printing Company, 1909), p. 17.

²¹ See, for example: Oregon State Federation of Labor. *Proceedings of the Eleventh Annual Convention of the Oregon State Federation of Labor* (Portland: Multnomah Printing Co., 1914), p. 19.

reflect popular public consensus, or simply the imposition of private group prerogatives?

The present paper attempts to offer answers to these questions.

Previous Research and Theoretical Considerations

Lawrence Goldberg and Warren Greenberg penned the main account of the hospital association issue in Oregon. Their piece served mainly to supplement a contemporary discussion of the economics of health care: they used their article to argue for the benefits of a competitive insurance market with real price competition. Thus, the account left much to be desired as an historical interpretation of the period. Goldberg and Greenberg did make two useful contributions, however. First, they provided an accurate chronology of the period, dividing the Oregon State Medical Society's strategy against the hospital associations into two phases. In the initial phase, Goldberg and Greenberg argued, the medical societies employed policy statements and alternative society-sponsored prepaid plans to indirectly limit hospital association activities. The second phase began around 1941, when the state medical society implemented the Oregon Physicians' Service, ultimately driving the hospital associations out of the market for direct care.²² Second, Greenberg and Goldberg did point out the issue of the distinctness of the medical profession. "Many physicians," they wrote, "believe their profession is

²² Lawrence Goldberg and Warren Greenberg, "Emergence of Physician-Sponsored Health Insurance: A Historical Perspective," *Competition in the Health Care Sector: Past, Present, and Future*, Warren Greenberg, ed. (Germantown, MD: Aspen Systems Corporation, 1978), pp. 238-244. To be fair to the United States Department of Justice, the Greenberg and Goldberg periodization was clearly taken from its briefs in the case of *United States v. Oregon State Medical Society*.

essentially different from any other profession or business because medicine deals directly with human life.”²³ Unfortunately, they failed to bring this issue into their analysis: a closer reading of both the District and Supreme Court opinions in the case of *United States v. Oregon State Medical Society* reveals that medicine’s unique professional status was a factor in organized medicine’s ultimate triumph over the hospital associations.

The Greenberg and Goldberg account leaves a great deal to be desired. By focusing mainly on the economic aspects of competition between hospital associations and physicians, they failed to address the role of public rulemaking bodies at all. This omission is surprising, especially given that Greenberg and Goldberg briefly discussed the Oregon State Medical Society’s selective application of its own rules of medical ethics in eliminating their commercial rivals.²⁴ Surely, they did not believe that public regulations played no role in the conflict? Furthermore, they presented a fairly isolated portrait of physician activities. In the Greenberg and Goldberg account, the contract medicine issue was fought out between physicians and hospital associations. The Oregon State Federation of Labor convention records, however, indicate that labor also sought to have an active voice in the issue.²⁵

²³ Ibid., p. 247.

²⁴ Ibid., pp. 233-238.

²⁵ I should also point out the Goldberg and Greenberg text contains an enormous number of factual inaccuracies, ranging from incorrect dates to dubious explanations of the specifics of state laws.

Paul Starr offered a far more complex, better-contextualized analysis of the hospital association issue in Oregon in his landmark text, *The Social Transformation of American Medicine*, notwithstanding his reliance on the Goldberg-Greenberg account. Starr used the Oregon situation as a case study to support his attempt to explain the “inability of corporate enterprise to insert itself successfully between producer and consumer in medical care under the economic conditions that prevailed in the early twentieth century.”²⁶ According to Starr, three factors converged to favor organized medicine over its commercial adversaries. First, physicians’ cultural authority gave them a solid base of power. Second, organized medicine gained control over the hospital by three means: its use of interns and residents in the operation of hospitals; its encouragement of professionalism among rank and file workers; and its employment of women who would not challenge male physicians’ authority and economic positions in auxiliary roles. Finally, unions, legislatures, the judiciary, and the public tended to support physicians against the hospital associations.

Starr’s work was an improvement over the Greenberg and Goldberg analysis. He specifically addressed the importance of the hospital as the new site at which medical care would be delivered, and discussed its role in introducing divisions into the medical profession between old-style generalist family practitioners and the emerging specialists. Starr also suggested that organized medicine did not operate in a vacuum when he argued that unions, legislatures, the judiciary, and the public played a role in handing victory to

²⁶ Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1976), p. 217.

the medical societies. Unfortunately, he left this as just that: a suggestion. In doing so, he dramatically oversimplified the situation. First, the Oregon example shows that the unions were hardly unwavering in their support of the medical societies. In fact, conflict between the two groups may have played an important role in limiting early attempts at restraining hospital association activities. Second, Starr's discussion of "the legislature" was theoretically unsophisticated. Oregon's legislature rarely handed victories to the anti-hospital association forces during the 1920s. Furthermore, the legislative outcomes of the 1930s that favored the medical society were not so much the product of a unified legislature, but rather the ability of organized medicine to exploit its control of key committee assignments. Thus, the legislature did not usually, if ever, speak as a unified body in opposition to the hospital associations. Instead, individual players used its rules and procedures to their advantage.

Despite the Oregon State Medical Society's view of itself as a distinct group with a unique professional status, no nuanced account of the hospital association issue can afford to ignore the general economic and regulatory context within which it was first debated. In fact, the issue initially arose at the same time that the American economy underwent a fundamental transformation from what Martin Sklar termed competitive to "corporate" capitalism.²⁷ Sklar argued that the transition to the corporate capitalist

²⁷ According to Sklar's analysis, competitive capitalism emphasized classical concepts of free competition and supply side equilibrium. The new corporate capitalism focused on business cycles and the ability of administered markets to fend off crises. See: Martin J. Sklar, *The Corporate Reconstruction of American Capitalism, 1890-1916: The Market, the Law, and Politics* (New York: Cambridge University Press, 1988).

economy resulted from the participation of social and political groups in key intellectual, legal, and legislative spheres.²⁸

At the heart of the new economy and the public response to it was an issue that lies at the core of the American political tradition: the supremacy of society over state. Sklar argued that that the species of “corporate liberalism” that emerged represented a compromise between extreme positions: regulatory corporate liberalism affirmed administered markets and allowed the growth of the regulatory state without embracing either totalistic statism or a minimalist-regulatory approach.²⁹ “Whatever their incongruities,” Sklar wrote, “regulatory laws and administrative practice tended, though far from consistently, to legitimize and recognize the new corporate order, its form of property, and its leading underlying assumptions.”³⁰ Thus, the transformation involved all classes, who, through their participation in the legislative sphere, played an important

²⁸ With this argument, Sklar attempted to displace the old narrative of the transformation, which held that the economic changes triggered public response and reform. Under that narrative, the public did not participate in the creation of the new economy. Its only contribution was the regulatory reaction to it.

²⁹ The policies of Presidents Theodore Roosevelt, Taft, and Wilson represented the three variants of corporate liberalism in Sklar’s account. Roosevelt’s statist-tending corporate liberalism retained private ownership, but subordinated property rights to private property. Under Taft’s minimalist-regulatory approach, public utilities would be distinguished from the general economy, but no modification of traditional property rights would occur: instead, the state would use its police power against unfair or monopolistic practices. Wilson’s regulatory corporate liberalism represented a middle ground between Roosevelt’s statism and Taft’s minimalism. The regulatory approach allowed the government to modify property rights in the interest of expanded human rights.

³⁰ *Ibid.*, p. 17.

role in not only reacting to, but also shaping and legitimizing the new economic conditions.³¹

Louis Galambos and Joseph Pratt also emphasized public participation in their analysis of Progressive era and 1920s regulations. In what they termed as the “corporate commonwealth” that emerged, business was only one factor in public decision-making. Frequent elections and an array of interest groups attempting to shape public policy led to a condition of confusion, Galambos and Pratt claimed. Thus, the federal and state legislatures produced regulatory rules in a piecemeal fashion. Those businesses that were most successful “in exerting pressure on the legislature and the executive branch” looked beyond control of markets and developed public relationships departments to influence the social sphere and the political sphere.³² Victory in the legislature, however, was not

³¹ According to Sklar, the heterogeneous nature of social classes in the 1890s prevented them from aligning against one another, avoiding gridlock, and forcing capitalists to proceed through compromise.

Corporate liberalism, according to some scholars, went hand-in-hand with welfare capitalism. In his review of the literature on this topic, Melyvn Dubofsky wrote, “exceptionally class-conscious corporate leaders, aware that reform served their self-interest better than repression did, replaced the policeman’s club with the soft glove of a more socially conscious welfare capitalism.” (Dubofsky, xiv) As Dubofsky noted, this was primarily the view of the New Left historians on the 1960s. Sklar’s currently-prevailing account departed only slightly from this view, Dubofsky argued. [Melyvn Dubofsky, *The State and Labor in Modern America* (Chapel Hill: University of North Carolina Press, 1994).]

³² Louis Galambos and Joseph Pratt, *The Rise of the Corporate Commonwealth: US Business and Public Policy in the Twentieth Century* (New York: Basic Books, 1988), p. 47.

necessarily the result of tight control over a local power base, but instead the product of adept lobbying.³³

The public statutes governing the certification and operation of hospital associations in Oregon were formulated in the new regulatory context that Sklar, Galambos, and Pratt described. As all three pointed out, however, the regulatory frameworks of the early twentieth century hardly required businesses to give up their control over private property and their attempts to control private markets. Correspondingly, any account of the hospital association issue in Oregon that hopes even to approach completeness will look beyond the private sector activities of the Oregon State Medical Society to those of the other interest groups, including the hospital associations and the Oregon State Federation of Labor. Such an account will also examine both private sector and public sphere attempts by these groups to resolve the issue in their favor – attempts which, by their very nature, would often bleed over from one sphere to the other.

Bringing the public sphere into the narrative necessitates a discussion of the role of the state in the hospital association conflict and, at an even more basic level, a definition of what the state is. In her classic essay, “Bringing the State Back In,” Theda Skocpol presented two contrasting, yet complementary definitions of the state. Under the first definition, the state acts as an autonomous actor. The state’s capacity to act, however, is not fixed. Instead, it is shaped and transformed by a number of factors: its relations with various societal groups; crises which force it to mobilize its potential in

³³ Ibid., pp. 92-93.

ways that it would not do otherwise; the integrity of its jurisdictional control and the loyalty of its officials; and its access to and ability to deploy financial resources. The second definition describes the state as an institutional structure. Under this definition, state structures and rules shape political outcomes. Skocpol wrote,

In this perspective, states matter not simply because of the goal-oriented activities of state officials. They matter because their organizational configurations, along with their overall patterns of activity, affect political culture, encourage some kinds of group formation and collective political actions (but not others), and make possible the raising of certain political issues (but not others).³⁴

The state continues to contribute to policy formulation and implementation under the second definition, but its role is passive rather than active. Skocpol claimed that these views of the state can and do complement one another. The latter definition, however, better suits the subject material addressed in the present paper.

The action over the hospital association issue played out between competing interest groups in several arenas, including the private sector and the legislature. Within the legislative arena, the state had little capacity to act. When it did act, it did so through the boards and commissions. Second, the boards and commissions were dominated by the relevant interest groups. When Skocpol discussed state capacity to act, she emphasized the roles of “organizationally coherent collectivities of state officials, especially collectivities of career officials relatively insulated from ties to currently dominant socioeconomic interests...”³⁵ Oregon’s workmen’s compensation laws

³⁴ Theda Skocpol, “Bringing the State Back In: Strategies of Analysis in Current Research,” in *Bringing the State Back In*, Peter Evans, Dietrich Rueschemeyer, and Theda Skocpol, eds. (Cambridge: Cambridge University Press, 1985), p. 21.

³⁵ *Ibid.*, p. 9.

required the governor to appoint three representatives to the State Industrial Accident Commission: a labor representative, an industry representative, and a public representative.³⁶ Thus, SIAC was hardly composed of relatively insulated career officials. The other boards and commissions relevant to the hospital association issue, including the Oregon State Board of Health and the office of the Oregon State Insurance Commissioner, also demonstrated close ties to various interest groups.

As labor historian Melvyn Dubofsky noted in the introduction to his state-centered account of modern American labor history, “many social scientists, though perhaps historians least of all, have been busily engaged in “bringing the state back in” to scholarship.”³⁷ Thus, an examination of current research in political science and law on the legislative process serves some use. William Eskridge et al broke theories of the legislative process down into three categories: interest group theories, proceduralist theories, and institutional theories.³⁸ The first two of these three are relevant to the present study.

Interest group theories, which hold that legislative outcomes reflect the preferences of interest groups, are best classed under what Dubofsky called the “pluralist model of public policy implementation.”³⁹ Two main views exist as to what legislative outcomes under interest group theory represent. When Dubofsky referred to the ‘pluralist

³⁶ Citation

³⁷ Dubofsky, p. xi.

³⁸ Eskridge, William, Philip Frickey, and Elizabeth Garrett. *Legislation and Statutory Interpretation* (New York: Foundation Press, 2006, 2nd Edition), pp. 69-116.

³⁹ *Ibid.*, p. xiv.

model,' he suggested that state officials mediate among contending interest groups. Some scholars, however, argue that the interest groups essentially negotiate among themselves, and the legislative vote on the point at issue is merely a rubber stamp on the decision reached by those groups. The present study makes only a limited reliance on interest group theory, in that it emphasizes the roles that the Oregon State Federation of Labor, the Oregon State Medical Society, the hospital associations, and occasionally, the casualty insurance lobby, played in the legislative process. There are two reasons behind this choice. First, the aforementioned groups were not merely interest groups: they actively controlled legislative seats and key committee posts. Second, the majority of the legislative outcomes that affected the hospital association issue were losses determined by committee votes. This fact suggests that factors beyond interest group dynamics influenced the hospital association debates.

Proceduralist theories lie more in line with what Theda Skocpol described when she presented the model of the state as an institutional structure. Under these theories, the legislature's procedural rules shape legislative outcomes. At the center of all proceduralist theories lies the concept of vetogates. These vetogates are essentially choke points, derived from constitutional, legislative, and historical rules, which have the ability to kill proposals. The most common vetogates are committee decisions, floor votes, and conference meetings. Proceduralist models are especially relevant to the present study, as both the hospital associations and the Oregon State Medical Society carefully exploited key committee posts to block what they deemed to be undesirable legislation.

Overview of the Argument

When the hospital association issue is set in its proper historical and theoretical context, a picture slightly different from the original Goldberg and Greenberg and Starr accounts emerges. The present study thus makes three main arguments. First, attempts to eliminate contract medicine extended back significantly further than these accounts suggest. The Oregon State Federation of Labor was largely responsible for these attempts, which they made through the legislative process. OrSFL failed to eliminate the hospital associations by these means due to procedural constraints and the federation's inability to form a lasting coalition with the Oregon State Medical Society. Second, when OSMS became more focused on the hospital association issue during the 1930s, it succeeded in imposing its own private code of ethics on the medical services market due in part to its ability to exploit legislative procedure. Finally, in 1952, the United States Supreme Court validated OSMS's imposition of its private code of ethics (in stark contrast to publicly-developed regulations) when it determined that the medical society's unique professional status exempted it from the rules that governed other sectors of the private market.

Limitations

This study certainly attempts to present a more nuanced interpretation of the hospital association issue in Oregon. At least two sets of limitations must be acknowledged, however. The first major set of limitations is inherent to the writing of legislative history. First, state legislature history presents special challenges. Not until

1961 did the Oregon state legislature begin keeping regular, continuous committee meeting notes.⁴⁰ Press reports occasionally reproduced debates. Full reports were rare, and newspaper stories were usually limited to a few sentences. Some alternative sources exist: the Oregon State Federation of Labor discussed certain bills at its annual convention; the medical profession debated measures in *Northwest Medicine*, the main journal for the medical societies of Oregon, Washington, and Idaho⁴¹; and *Oregon Voter* contained long stories on selected pieces of legislation and the associated committee activities. These sources, however, have their biases. The *Oregon Voter* magazine, for example, received a constant flow of funding from National Hospital Association advertisements.⁴² The present study attempts to corroborate accounts wherever possible, and to draw carefully qualified conclusions elsewhere.

Even legislature-recorded committee meeting minutes present certain methodological difficulties, however. In his widely-cited opinion in the case of *In the matter of Russell E. Sinclair, Sr. and M. Marguerite Sinclair*, Judge Frank Easterbrook launched five arguments against the use of legislative history in interpreting statutory text. First, reports are often written by unelected staffers. The reports do not necessarily reflect legislative consensus, especially because those vested with the power to vote on

⁴⁰ “Oregon Legislative Records Guide,” Oregon State Archives, Online, accessed 04/25/2010, http://arcweb.sos.state.or.us/legislative/legislative_guide/legislative_guide/legal.html#Committee%20Minutes%20and%20Audio%20Tapes.

⁴¹ Larsell, *The Doctor in Oregon: A Medical History* (Portland: Binford & Mort, 1947).

⁴² See, for example: National Hospital Association, [Advertisement], *Oregon Voter*, Vol. 39, No. 2, Oct. 11, 1924, p. 60.

legislation may never read these reports. Second, legislative history can be “loser’s history.” A defeated group might attempt to write reports that will cause judges to interpret the new statutes in their favor. Third, the use of legislative history imposes ambiguous legal obligations and standards. Because it can be interpreted in so many different ways, statutes’ meanings might shift constantly, and the laws will lose their power to guide action in the private sector. Fourth, legislative history gives creative judges more tools to play with: they can easily warp its meaning to support practically any position. Finally, legislative history lacks democratic legitimacy. Committee reports are not subject to the bicameralism and presentment requirements contained in Article I, Section 7 of the United States Constitution. Easterbrook’s arguments boil down to the simple proposition that sources of legislative history can have multiple meanings, closely tied to their writers’ and readers’ preferences. This is true of all of historical texts, but the stakes are especially high for these materials. The present study acknowledges the weaknesses of these sources, and does its best to keep their biases in mind. The use of these sources herein has no normative implications for statutory interpretation.⁴³

A second limitation to the study must be acknowledged. This study aims to examine the development of public and private attempts to “regulate” contract medicine and hospital associations. In doing so, it focuses mainly on the activities of interest groups both in the legislature and in the private sector. The problem of agency capture plays an important role in the analysis. Little attention, however, was paid to the internal

⁴³ 870 F2d 1340 *In the Matter of Russell E Sinclair Sr and M Marguerite Sinclair*. Online. Accessed 04/25/10. <http://openjurist.org/870/f2d/1340/in-the-matter-of-russell-e-sinclair-sr-and-m-marguerite-sinclairs>.

dynamics of the regulatory agencies. In his study of the Texas Railroad Commission, William Childs argued that historians should consider eight factors when analyzing regulation in America in the first half of the twentieth century. Economic, legal, and interest group forces number among these factors. Childs, however, also points out that “[i]deology and cultural factors matter in regulation – sometimes as much as or more than economic and legal forces.” Childs divided culture into three categories: agency culture, regulatory culture, and regional culture.⁴⁴ The omission of a focused analysis of these cultures is not so much one of willful neglect, but rather a general unavailability of sources.

Chapter Overview

Each of the second, third, and fourth chapters of this study deals with both a consecutive section of the chronological progression of events in the contract medicine issue, and also a piece of the study’s argument. Chapter two examines OrSFL’s attempts to eliminate contract medicine, and argues that procedural and interest group factors prevented a public resolution of the issue. Chapter three turns to OSMS’s attempts to resolve the issue by imposing its private code of ethics on the medical services market, and attempts to show that the same procedural factors which prevented a public resolution of the issue gave the medical society the autonomy it needed to pursue its private one. Finally, chapter four addresses the United States Supreme Court’s

⁴⁴ William R. Childs, *The Texas Railroad Commission: Understanding Regulation in America to the Mid-Twentieth Century* (College Station: Texas A&M University Press, 2005), pp. 7, 262-264.

adjudication of the issue in *United States v. Oregon State Medical Society*, and shows how the medical society was able to protect its autonomy through not only legislative, but also judicial processes.

CHAPTER II

LEGISLATIVE DYNAMICS, THE OREGON STATE FEDERATION OF LABOR,
AND THE HOSPITAL ASSOCIATION PROBLEM, 1917-1929

Secretary Stack thought it practically impossible to secure relief through action of the Legislature. He was of the belief that only through the initiative and referendum could workers hope to secure necessary relief.

- Minutes of the Seventeenth Annual Convention of the Oregon State Federation of Labor, October 1919

Between 1917 and 1929, the hospital association issue was mainly contested within the public realm through the Oregon state legislature. The 1917 legislative session marked the starting point for this period because in that year, the hospital associations succeeded in entrenching themselves by persuading the legislature to delegate regulatory power to the Oregon State Insurance Department. This body treated the hospital associations highly favorably: the state insurance commissioner and the associations appear to have had a close and comfortable relationship. Over the twelve years that followed, the anti-hospital association forces attempted to wrest regulatory power from the insurance department and to give it instead to the physician-dominated State Board of Health, to forcibly alter fee collection practices, and to completely abolish the hospital associations' role in the market for medical and surgical services for occupational injuries. These forces failed for several reasons: the legislature's structure and rules enabled the hospital associations to block these actions; the anti-hospital association coalition itself suffered from internal divisions; and groups within the coalition were unable to come to internal agreement. By the end of the decade, the impossibility of uprooting the hospital

associations through the legislative process became very clear, and the Oregon State Federation of Labor began to experiment with alternatives.

The Insurance Code of 1917 and the Entrenchment of the Hospital Associations

Two major issues regarding hospital associations dominated the 1917 legislative session. The first issue was state supervision of the deduction of fees. The second, somewhat related issue was the certification of hospital association business transactions. Although both issues would eventually come to the forefront of the hospital association debate, the 1917 session seems unusual in that neither aroused very much controversy.

When the Oregon State Federation of Labor (OrSFL) opened its annual convention at Labor Union Hall in Salem on January 22, 1917, the issue of hospital fees briefly occupied the convention's attention. In his speech to the convention, State Industrial Accident Commissioner W.M. Marshall "enumerated abuses, including one of questionable hospital fees, which he though [sic] should be corrected." When the convention prepared its instructions to the Federation's legislative committee, the questionable fee problem stood among its three goals for the twenty-ninth legislative assembly. Representative Sweeney took the lead in introducing "a bill to correct the hospital fee evil."⁴⁵ On January 26, 1917, Sweeney's H.B. 346 received its first reading. The bill gave employees full control over the approval of medical service plans, with even already-existing plans subject to the bill's requirements. Under the proposed law,

⁴⁵ Oregon State Federation of Labor. *Year Book for Nineteen Seventeen*, pp. 33-35. (Oregon Historical Society Research Library).

wage deductions could only be made if fifty-one percent of the employees voted in favor of the plan. The employees were also given control over the selection of the company physician and surgeon, with the only requirement between that the two would be in good repute with the medical profession. Wage deductions were to be handled by an elected executive committee of employees, who would report directly to the Oregon State Commissioner of Labor.⁴⁶

The Committee on Medicine, Pharmacy and Dentistry introduced a substitute for H.B. 346 on February 17, 1917, when H.B. 549 was read for the first time. The bill aimed at one of labor's main concerns, namely the unlawful retention of hospital association fees by employers for non-medical uses. The authority to enforce this prohibition fell on the State Industrial Accident Commission (SIAC). The bill instructed SIAC to cancel a contract service if it deemed the physician incompetent or the service inefficient. The bill also aimed at reducing the fees employees paid, and gave SIAC broad discretion in determining fee levels: employees dissatisfied with the amount or manner of fee collection could complain to the commission. The commission's decision on the matter could make the fee in question illegal based on a reasonableness standard.⁴⁷

⁴⁶ Oregon. House. *House Bill No. 346*. Twenty-Ninth Legislative Assembly, Regular Session, Jan. 26, 1917.

⁴⁷ Reasonableness standards usually reserve wide discretion to the commissions or courts in applying the applicable provisions. Because H.B. 549 did not provide any specific standards or examples of unreasonable fees, SIAC would have been able to determine the "reasonableness" of the fees on its own terms. [Oregon. House. *House Bill No. 549*. Twenty-Ninth Legislative Assembly, Regular Session, February 15, 1917.]

The substitute bill passed the House on February 16 on a vote of 31 to 17.⁴⁸ The reasons behind the 17 representatives' opposition to the bill are not entirely clear. Representative K.K "Kap" Kubli was a well-known opponent of labor. According to the *Oregon Voter* magazine, he was later elected to the 1919 legislature "in spite of every effort made by Organized Labor to defeat him."⁴⁹ The magazine, however, considered Representative Ivan G. Martin to be a friend of labor. He, too, opposed the bill. In the Senate, the only opposition came from Senators Robert S. Farrell and W.H. Strayer when the bill passed on February 19. Both senators were regarded as moderately pro-labor. Overall, the opposition to the bill did not appear to generate a coherent line of attack, and the apparent lack of press coverage suggests that it was not very controversial.

The state's revisions to the insurance code similarly aroused little controversy. According to *Oregon Voter*, the insurance code was long in need of an overhaul by 1917. The code had been haphazardly built over many legislative sessions, and the result was conflicting provisions, duplications, and even entire sections invalidated by Oregon Supreme Court decisions. Due to the code's history, the state Insurance Commission was concerned that attempts to correct the problem would be stymied unless a coherent set of codes were presented to the legislature. Thus, the state assembled a committee of eight to

⁴⁸ State of Oregon. *Journals of the Senate and House of the Twenty-Ninth Legislative Assembly*. Salem, Oregon: State Printing Department, 1917, p. 467.

⁴⁹ C.C. Chapman, "Who's Who in the House," *Oregon Voter*, Vol. 16, No. 1 Jan. 4, 1919, p. 53. The magazine did not publish its regular "who's who" in 1917, and thus some biographies are missing.

propose new legislation, appointing equal numbers of business and insurance representatives, with the insurance commissioner as the committee's ex-officio chair.⁵⁰

The National Hospital Association and other hospital associations appear to have had some influence in the drafting of the new code. The state's casualty insurance companies made a concerted effort to bring the hospital associations under the same capital and surety bond requirements they themselves faced. In an October 13, 1916 letter to Insurance Commissioner Harvey Wells, Oregon Surety & Casualty Company General Manager C.H. Weston argued that it was unfair to treat hospital associations any differently than other insurance companies. He wrote, "We believe that the liability of the Hospital Association exceeds the liability of the Health and Accident Insurance Company which sells cash indemnity policies." The only fair way to proceed to was require hospital associations to raise \$100,000.00, or, at the very least, \$50,000.00. This might eliminate several hospital associations, he conceded, but the remaining associations could "join hands" to raise the necessary capital.⁵¹

Commissioner Wells was closely tied to the hospital associations, and apparently did his best to protect their interests as ex-officio chair. In a December 22, 1916, letter to H.J. Slusher, manager of the Lumbermen's Hospital Association, he wrote of the "concerted effort on the part of a few to bring hospital associations under the requirements of domestic insurance companies," reassuring Slusher that he would

⁵⁰ Harvey Wells, Letter to W.J. Clemens, Feb. 20, 1915, Oregon State Archives, Acc. 60A 31/3-4, Box 91 of 116, 5/8/6/6.

⁵¹ C.H. Weston, Letter to Harvey Wells, Oct. 13, 1916, Oregon State Archives, Acc. 60A 31/3-4, Box 91 of 116, 5/8/6/6.

“cooperate in any way possible to protect the interests of any legitimate hospital associations...”⁵² In another letter a month prior, Wells reassured National Hospital Association General Manager C.C. Bechtold that he would push Bechtold’s recommendations for the new code on the committee. He wrote, “This is to advise that I will try and get the general committee to permit me to make this part of the code... However, if it does not become a part of the code I personally will recommend it to the Legislature and request that it become a part of the insurance code.”⁵³

Exactly what the contents of Bechtold’s recommendations were is unclear from the documentary record. The National Hospital Association, however, later expressed enthusiasm for both the insurance code and H.B. 549. An NHA manuscript which cannot be described less than odd for its frequent tone shifts claims that “[b]oth of these laws were enacted largely through the efforts of the National Hospital Association.”⁵⁴ What is clear is that the state’s hospital associations, and especially the National Hospital Association, accepted regulation by the Insurance Commission, and would later resist attempts to shift power to supervise their affairs to other departments.

The Committee of Eight eventually presented their recommendations as Senate Bill No. 278 on February 6, 1917. Most importantly, the bill legitimated medical aid

⁵² Harvey Wells, Letter to H.J. Slusher, December 22, 1916, Oregon State Archives, Acc. 60A 31/3-4, Box 91 of 116, 5/8/6/6.

⁵³ Harvey Wells, Letter to C.C. Bechtold, November 6, 1916, Oregon State Archives, Acc. 60A 31/3-4, Box 91 of 116, 5/8/6/6.

⁵⁴ “History.” Oregon Historical Society Research Library, Farwest American Assurance Records, Mss 2863, Box 1 of 8, Folder 1.

contracts between individual doctors or hospital associations and employers for both occupational injuries and non-occupational sickness. The individual doctors and associations were placed under the supervision of the insurance commissioner, who was given the power to issue the certificates necessary for transacting business in the state. The bill set very strict standards for the awarding of the certificates. The doctor or association was required to put up capital stock of \$5,000.00 (significantly less than the amount demanded by the Oregon Surety & Casualty Company) and a surety bond of \$10,000.00. The bill also required the associations to license their sales agents under the same procedures as required of insurance agents. So long as these requirements were met, the bill made it “the duty of the Insurance Commissioner of this State to issue a certificate authorizing such corporation, society, firm, partnership or individual to transact business under the provisions hereof.”⁵⁵ Simply put, the insurance commissioner himself had very little discretion in the certification of new hospital associations.

The bill sailed through both houses of the legislature with relatively little opposition, and the governor signed it into law on February 16, 1917. Only eight senators opposed it, and a lone representative voted against it. As was the situation for H.B. 549, the opposition to the insurance code seems relatively incoherent. Among the “nay” voters were two practicing lawyers, a businessman, a commercial fruit grower, and a physician in active practice.⁵⁶ Curiously, however, Senator Dr. J.C. Smith (R-Grants

⁵⁵ Oregon. Senate. *Senate Bill No. 278*. Twenty-Ninth Legislative Assembly, Regular Session, Feb. 6, 1917.

⁵⁶ “Who’s Who in the Legislature,” *Oregon Voter*, Vol. 16, No. 1 Jan. 4, 1919, p. 11.

Pass), another physician, voted for the bill. The medical society would later throw its weight behind a bill which would shift certification from the insurance commission to another department. Smith's support of the bill is significant because he was actively involved in the Oregon State Medical Association's policy activities. For example, Dr. Smith represented the society's Committee on Public Policy when he proposed changes to the workmen's compensation system at a July 17, 1918 meeting of the OSMA House of Delegates.⁵⁷ The House of Delegates did not touch the insurance code issue at all in its 1918 meeting, which suggests that organized medicine, at least within the state of Oregon, had not reached any degree of consensus on the hospital association issue even shortly after the legislature passed the 1917 reforms.⁵⁸

An article in the May, 1917 issue of the *Portland Medical Sentinel* suggests the same lack of consensus. Doctor Clark E. Saunders, Superintendent of the Medical Department of the C. & O. Lumber Company in Brookings, Oregon, described his experience as a company doctor. Saunders initially approached contract medicine with skepticism. He wrote that he remembered "being present at a certain state society meeting" as a young physician, "when the subject of the "Vile" Contract Doctor was

⁵⁷ "Minutes of the House of Delegates of the Oregon State Medical Association," *Northwest Medicine*, Sept, 1918, Vol. 17, No. 9, p. 273.

⁵⁸ Oregon State Federation of Labor records suggest that both Senator Wood (the physician who opposed the bill) and Senator Smith were contract doctors. Thus, even among contract doctors, the hospital association issue was probably far from settled in 1917. [Oregon State Federation of Labor. *Year Book for Nineteen Hundred Twenty*, 1920, p. 20.]

being expatiated on by one of the elite members of our very honorable calling...”⁵⁹

Saunders launched two main arguments in favor of contract medicine as he practiced it. First, his status as company doctor allowed him to take care of the health of the entire camp, not just the individual patients. He was given “complete charge... over and for, things sanitary and hygienic in all the Company operations.”⁶⁰ Second, his presence in the camp encouraged patients to resolve medical problems early instead of procrastinating. The overall effect of his presence was improved efficiency and improved health. Saunders summarized his piece, writing, “I believe that the Industrial Physician has come to stay.”⁶¹ The medical societies had no choice but to accept and improve contract medicine.

Saunders’ piece is notable not merely because it demonstrates a lack of consensus over the contract medicine issue, but also because it is written by a single contract doctor. Saunders did not defend the corporate practices of the hospital associations, but merely the activities of the single, probably medical society-affiliated contract physician. The Oregon State Medical Society by no means endorsed contract medicine, but it seemed to reserve its most intense attacks for the hospital associations.

OrSFL took a similar stance as it came to vigorously oppose hospital associations by the conclusion of its 1919 convention. The federation’s position at its 1918 annual

⁵⁹ Clark E. Saunders, “A New Specialty,” *Medical Sentinel*, Vol. 25, No. 5, May, 1917, p. 3485.

⁶⁰ *Ibid.*, p. 3486.

⁶¹ *Ibid.*, p. 3490.

convention, however, was far muddier. The convention passed a resolution which declared that the workers should be permitted to choose their own physicians, something that the hospital association system would not permit. Furthermore, the convention followed up on its 1917 legislative activities, declaring that SIAC should be given more power to supervise payments for medical services and hospital accommodations. Beyond supervision, the convention reached no consensus on whether or not employers should be permitted to deduct hospital fees. The main problem with the hospital fee deduction, Delegate Arthur Jones pointed out, was one of mobility. A worker would join a lumber camp, pay his hospital fees for the entire month, and leave to work for another camp soon after. His payment would not carry over, and as a result, the workers would be forced to pay redundant fees. As a compromise, Jones suggested that workers pay their fees in smaller, more spread-out installments of 4 cents per working day. Hospital fees served an important purpose, Jones' "objection being only to the manner of collection usually followed."⁶²

By 1919, the State Federation of Labor adopted a stronger anti-hospital association stance. The federation's executive board continued to push for free choice of physician and supervision of payments by SIAC. To these positions, the convention added a resolution, adopted on January 9, 1919. The resolution stated that the federation was "opposed to all hospital associations operated for profit," and said that it would "unanimously go on record as being opposed to all hospital associations conducted on

⁶² Oregon State Federation of Labor. *Year Book 1918: Proceedings of the Fifteenth Annual Convention*. Portland: Allied Printing, 1918, pp. 21-22.

compulsory monthly dues, which are set by the employer.”⁶³ The 1919 resolution represented a departure from the compromise Jones suggested at the 1918 convention. The exact reasons for the shift in the federation’s stance on the hospital association issue are unclear, but the legislative battles which followed just weeks later offer some tentative answers.

The hospital associations’ opponents introduced a package of two bills to the Oregon House on January 31, 1919. Representative Eugene E. Smith, described as “Multnomah County’s well known labor representative” by his opponents, sponsored House Bills 286 and 287.⁶⁴ These bills were intended to replace the compromise reached in H.B. 549 during the 1917 legislative session. House Bill 286 sought to write OrSFL’s objection to compulsory monthly hospital association dues into law. By making it unlawful to deduct from employee wages for medical purposes, “except as may be required by the workmen’s compensation laws,” H.B. 286 eliminated all non-workmen’s compensation-based medical coverage by hospital associations. The bill also gave employees far more leverage in pursuing their grievances: instead of appealing to SIAC, the employee was given cause of action to pursue his claims through the judiciary. The bill instructed the latter to give hospital fee deduction claims precedence over all cases

⁶³ Oregon State Federation of Labor. *Year Book 1919: Proceedings of the Sixteenth Annual Convention*. Portland: Allied Printing, 1919, pp. 31-32.

⁶⁴ Prudential Hospital Association, “House Bills 286 and 287,” *Oregon Voter*, Vol. , No. , p. 25.

except criminal cases. Furthermore, the bill established a remedy of punitive damages “three times the amount for which the verdict was rendered, but not... less than \$25.”⁶⁵

The measure’s companion bill, H.B. 287, shifted the regulation and licensing of the hospital associations from the State Insurance Commission to the State Board of Health. The bill had two particularly notable features. First, it gave the Board of Health much wider discretion in revoking certificates than the 1917 insurance code granted the Insurance Commission. If an employee filed a complaint against a hospital association, the board had merely to hold a hearing before it could revoke the association’s certificate. The bill set out no specific standards for the board to adhere to. Second, the bill applied only to hospital associations. The 1917 act gave the insurance commissioner jurisdiction over “any individual, firm, association, or company, which may contract with any employer for the medical, surgical or hospital care and attention of his employes.”⁶⁶ House Bill No. 287, however, specifically exempted fraternal orders, and applied only to “[a]ll hospitals and hospital associations that collect regular installments of money... periodically from individuals, families, organizations, corporations or partnerships...”⁶⁷ The bill essentially sought to deregulate individual contract doctors, and preserved a protection of the labor movement’s fraternal benefit societies written into the 1917 code.

⁶⁵ Oregon. House. *House Bill No. 286*. Thirtieth Legislative Assembly, Regular Session, Jan. 31, 1919.

⁶⁶ Oregon. House. *House Bill No. 549*. Twenty-Ninth Legislative Assembly, 1917, p. 1.

⁶⁷ Oregon. House. *House Bill No. 287*. Thirtieth Legislative Assembly, 1919, p. 1.

Because the documentary record is rather thin, the exact motives behind two bills are rather difficult to deduce. In an article in the *Oregon Voter* magazine, R.M. Standish suggested that the casualty insurance companies actively riled up organized labor.⁶⁸ He wrote, “[C]loser investigation discloses other interests behind this antagonism [toward hospital associations], including some of the casualty insurance companies, whose field of endeavor has to some extent been invaded by the hospital associations.”⁶⁹ The casualty insurance companies’ letters to Insurance Commissioner Harvey Wells preceding the enactment of the 1917 insurance code pertaining to hospital associations may support Standish’s contention that the companies were behind the legislation. Standish specifically mentioned the companies were upset that the hospital associations had to meet significantly lower capital and surety bond requirements. If the casualty insurance companies were behind the legislation, however, they must have acted mostly behind the scenes.

The medical societies may also have played a role in the bills. The hospital associations’ statements in *Oregon Voter* magazine suggest, not without evidence, that the bills were an effort by organized medicine to clamp down on association activity. The National Hospital Association complained that H.B. 287 would switch regulatory oversight of the hospital associations from the Insurance Commission to the State Board of Health. If the change were made, the NHA asserted, “it is naturally feared that

⁶⁸ Exactly why the casualty insurance companies and the Oregon State Federation of Labor may have formed an alliance in 1919 is unclear. That the alliance was temporarily mutually-beneficial is not outside the realm of possibility, however.

⁶⁹ R.M. Standish, “Hospital Insurance,” *Oregon Voter*, Vol. No. Jan. 18, 1919, p. 15.

hospital associations would suffer from unjust regulation by a board, which in the nature of its work, is ordinarily controlled by and made up of representatives of the self-styled ETHICAL PHYSICIANS, who are known to be hostile to hospital associations.”⁷⁰ The Prudential Hospital Association made similar claims, and latched onto the proposed exemption of individual contracts from the board’s regulatory oversight. “The contract doctor...,” Prudential argued, “is more or less recognized by the ethical medical fraternity, yet his corporate competitors are viewed as a menace.”⁷¹ While the texts of the bills do cast suspicion on the medical fraternity, however, the actual progress of the bills through the legislature suggests that the issue was not so simple.

House Bills 286 and 287 fared poorly in the House. After the bills’ first readings on January 31, they were referred to the House Committee on Labor and Industries on February 3. The committee deliberated on the bills, and ten days later recommended two amendments to H.B. 286. First, they recommended excepting companies operating through interstate commerce from the bills requirements. Second, they proposed allowing medical service contracts for non-workmen’s compensation care, something the original bill strictly prohibited. By the next day, the impossibility of passing the two bills became clear, and the committee substituted a new bill, H.B. 445, once again sponsored by Representative Smith. This bill preserved SIAC’s supervisory power over fee collection, and enhanced the commission’s rule-making authority. Furthermore, it gave

⁷⁰ National Hospital Association, “House Bills 286 and 287,” *Oregon Voter*, Vol. No. Jan 18, 1919, pp. 25-26.

⁷¹ Prudential Hospital Association, “Hospital Associations and Contract Doctors,” *Oregon Voter*, Vol. No. Jan 18, 1919, p. 27.

workers more say in the signing of hospital contracts by requiring approval by a vote of at least 51 percent of a plant's employees. As an apparent concession to hospital associations and employers, however, the bill grandfathered in already-existing contracts.⁷² On the evening of February 19, the compromise bill passed the House by a vote of 44-to-2.⁷³ Upon transmittal to the Senate, however, the bill died. Soon after, *Oregon Voter* lamented the bill's death, writing, "[e]nactment of this bill would have provided a compromise adjustment which seemed to be satisfactory to all parties interested." As the situation was, the magazine predicted that the legislature would once again have to face the hospital association issue when it convened in 1921.

Why did all three bills die? OrSFL Legislative Committeeman Walter G. Lynn offered his analysis at the federation's annual convention the next year. According to Lynn, House Bills 286 and 287 had to be withdrawn for three reasons. First, the "array of contract doctors and attorneys for hospital associations" who held seats in the thirtieth legislative assembly strongly opposed the reforms. Second, the other legislators did not want to leave workers without any kind of hospital protection. Union support of the bill was not enough to override these legislators' concerns. Finally, the idea of the 51 percent approval compromise made the original bills less attractive. Once this compromise gained the House's near-unanimous support in the form of H.B. 445, however, it was killed in the Senate. Lynn explained,

⁷² Oregon. House. *House Bill No. 445*. Thirtieth Legislative Assembly, Regular Session, Feb. 14, 1919.

⁷³ State of Oregon. *Journals of the Senate and House of the Thirtieth Legislative Assembly*. Salem, Oregon: State Printing Department, 1919, pp. 377, 382, 450, 458, 501.

The bill... went to the Senate, and to a committee on which were two contract doctors, Wood and Smith. Just at a time when I had every reason to believe it would be passed, opposition from Attorney U'Reu and Brother Frank Hannan, appeared: the committee reported unfavorably, and the bill was indefinitely postponed.⁷⁴

Senators Wood and Smith had previously split on the insurance code, and both their activities, and those of the contract doctors in the House, suggest that the Oregon State Medical Association either had an incoherent stance on hospital associations, a weak legislative strategy, or both. Some of the contract doctors, of course, may have been employed by hospital associations, and their opposition to the bills, as well as that of the hospital association attorneys, makes perfect sense. Other contract doctors, however, including Senator Smith, were active and influential members of the medical societies. The medical societies stood to gain from switching oversight of the hospital associations from the Insurance Commission to the Board of Health.

The absence of firm, absolutely coherent evidence of the motives and behind-the-scenes activities regarding the 1919 hospital association bills limits the conclusions that can be drawn. The session's events do suggest a few things, though. First, labor, insurance, and perhaps medical society groups probably formed coalitions to try to limit or even destroy the hospital associations. Second, OSMA had yet to develop a well-articulated stance on the hospital association issue, and the votes of legislator-physicians may have reflected this. Third, even without commanding a clear majority, pro- and anti-

⁷⁴ Oregon State Federation of Labor. *Year Book for Nineteen Hundred Twenty*, 1920, p. 20.

hospital association groups could affect public policy outcomes by securing seats on influential legislative committees and possibly even state boards and commissions.⁷⁵

Changes Leading up to the 1921 Legislative Session

In the two year span between the close of the 1919 legislative session and the inevitable showdown that the *Oregon Voter* magazine had predicted after the Senate killed H.B. 445, three major developments occurred. First, the medical societies began to develop a clearer stance on the hospital association issue. Second, the State Industrial Accident Commission attempted to take independent action against the hospital associations. Finally, the governor appointed a “Committee of Fifteen” representatives of labor, industry, and the general public to recommend changes to the workmen’s compensation system, including the 1917 insurance code provisions relating to hospital associations.

In February 1920, the Portland City and County Medical Society adopted a strong anti-hospital association resolution.⁷⁶ The resolution read, “No physician or surgeon who employs an agent to solicit medical or surgical practice, or is employed by an organization that employs an agent to solicit medical or surgical practice, or owns stock

⁷⁵ For information on the battle over compulsory health insurance in the 1910s, see: Ronald L. Numbers, *Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912-1920* (Baltimore: John Hopkins University Press, 1978).

⁷⁶ The Portland City and County Medical Society later became the Multnomah County Medical Society, discussed in Chapter 3. See: Larsell, *The Doctor in Oregon: A Medical History* (Portland: Binford & Mort, 1947), p. 200.

in such an organization, is eligible to membership in this Society.”⁷⁷ Within the medical community, there was no doubt about the intent behind the resolution: *Northwest Medicine* reported, “This action was directed against hospital associations which employ agents for this form of solicitation.”⁷⁸ Even if the medical society had perfect aim, however, *Oregon Voter* predicted that the resolution would probably eventually bar non-association contract doctors.

The medical society was probably not overly concerned about protecting non-hospital association contract doctors. An April 1920 editorial in *Northwest Medicine* placed contract practices into three categories, none of which recommended it highly: “excusable,” “questionable,” and “wholly iniquitous.” The editorialist argued that contract doctors undercut other physicians by offering their services at a reduced fee. Furthermore, he charged, contract medicine promoted intellectual laziness: the contract physician might simply secure a large number of contracts, and then rest on his laurels instead of continuing to improve the quality of his service. One solution to the contract medicine problem, the editorialist half-heartedly suggested, was the establishment of mutual benefit associations among employees. Administered by a “well-chosen group of men,” the beneficial association could purchase medical services at market value when most desirable. Such a system would clearly benefit the medical profession, which would gain freedom from the price competition posed by the contract physicians.⁷⁹ Of

⁷⁷ “Tradition vs. Progress,” *Oregon Voter*, Vol. No. , Feb. 14, 1920, p. 299.

⁷⁸ “Use of Agents Forbidden,” *Northwest Medicine*, Vol. 19, No. 3, March 1920, p. 79.

⁷⁹ “Contract Medicine,” *Northwest Medicine*, Vol. 19, No. 4, April 1920, p. 106.

course, the editorialist did not speak for the medical society, but his words did reflect the more moderate strain of opinion on the contract medicine issue. Contract medicine was inherently suspect, and the society had to approach it carefully.

Even the editorialist's mutual benefit association solution posed a problem for organized medicine. In his own words, the solution approached "dangerously near the question of health insurance..."⁸⁰ Just fresh from its near-miss encounter with state medical insurance, the organized medicine was extremely wary of any solution which might lead to the adoption of such a system. An editorial in the May, 1920 issue of *Northwest Medicine* summed the problem up perfectly:

Commercialism on the one hand and socialism on the other threaten this independence... With... cooperation of all factors involved, we need never bow our heads to the political boss, or walking delegate of either capital or labor.⁸¹

In fact, relations between organized labor and the medical profession appear to have been strained around this time. In September 1919, the Oregon State Federation of Labor rejected a charter application by 12 Portland physicians who sought to form a union affiliate with the OrSFL. As fee earners, the OrSFL president argued, the physicians were not laborers.⁸² On top of this minor issue lay the even more critical question of state medical insurance. By 1920, the physicians opposed the idea, but the OrSFL seemed more receptive. In his report on the failed 1919 legislative battle, Walter G. Lynn

⁸⁰ Ibid.

⁸¹ "Standardization of Hospitals Versus State Medicine," *Northwest Medicine*, Vol. 19, No. 5, May, 1920, p. 131.

⁸² "Physicians and the State Federation of Labor," *Northwest Medicine*, Vol. 19, No. 3, March, 1920, p. 79.

remarked, “And equally difficult will it be to secure state health insurance” as an alternative to the hospital associations. “Opposition to state health insurance is very strong,” he concluded.⁸³ The OrSFL’s support for state health insurance showed no sign of abating in the months leading up to the 1921 legislative session, and ultimately this split between organized labor and organized medicine may have weakened both groups’ chances to successfully combat the hospital associations come 1921.

In the meantime, the State Industrial Accident Commission undertook its own action against the hospital associations. Around early January 1920, SIAC attempted to persuade employers around the state to voluntarily give up hospital association contracts and come under the state system. In its letter to the employers, the commission wrote, “If it is desirable to have a hospital contract at all, we suggest that the hospital contract apply only to the care of your employees and their families in time of sickness or in cases of injury which does not occur in the course of employment.”⁸⁴ The commission’s suggestion would consolidate all care for occupational injuries under state insurance, threatening to significantly reduce the hospital associations’ market shares to only non-occupational medical care.

The National Hospital Association, a private, local hospital association, did not react kindly to SIAC’s suggestion. As the state’s largest hospital association,⁸⁵ NHA

⁸³ Oregon State Federation of Labor. *Year Book for Nineteen Hundred Twenty*, 1920, p. 20.

⁸⁴ “Suggestion Unpopular,” *Oregon Voter*, Vol. No., Feb 21, 1920, p. 336.

⁸⁵ In 1920, the National Hospital Association reported \$254,356.59 in revenue. The Astoria-based Lumbermen’s Hospital Association reported the next-highest figure, at

directly attacked the commission's plan to bring all occupational injuries under state insurance. In a letter to its clients, SIAC wrote,

Their suggestion in paragraph 2, regarding the contract applying only to sickness and injuries received out of working hours is not practical. It is not only important that employes [sic] be provided with proper Medical and Surgical Services, but that a means of properly obtaining this service be established. Sickness and injuries are so closely related that the means of providing relief should not be separated. Remove from you the right to contract for the care of your men on account of injuries and your interest in the care of your men in case of sickness is lessened. Would this not result in a great many instances of a return to the old "pass the hat" system so badly abused a number of years ago?⁸⁶

Separating occupational and non-occupational injuries would be impossible, NHA contended. Even if the association was not completely correct about this, the move would certainly have cut into their market share. The NHA may have been correct in its suggestion that the SIAC move would eliminate the hospital associations completely. Despite the commission's stated goals of ending the mistreatment of workers under the contracts and providing free choice of physician, the *Oregon Voter* magazine reported that the "evident intent of this suggestion is to overthrow the present system of dealing with private concerns and to establish in its place a State Health Insurance System..."⁸⁷ This line of analysis had some support, even if it was tainted by *Oregon Voter's* obvious

\$40,630.14. Oregon. Insurance Department. *Annual Report of the Insurance Commissioner for the Year Ending December 31, 1921* (Salem: State Printing Department, 1922).

⁸⁶ C.C. Bechtold, Letter, Jan. 13, 1920, Oregon Historical Society, Mss 2863, Vol. 11, 1909-1920, page 42.

⁸⁷ "Suggestion Unpopular," *Oregon Voter*.

pro-hospital association bias.⁸⁸ Henry T. Mears, a Portland-based employer, thought that SIAC's proposal was "a labor union move, as the Commission is now mostly under the domination of the union element."⁸⁹ Given OrSFL's support for state health insurance, Mears' contention may have had some merit.

Another argument complicated the situation, however. According to *Oregon Voter*, "the proposed suggestion of the Commission may have been prompted in part by the so-called ethical medical fraternity."⁹⁰ Organized medicine would certainly have been willing to overthrow the hospital associations. It would not, however, have been likely to support a complete system of state health insurance for both occupational injuries and non-occupational illnesses. Thus, to the extent that it may have participated in urging SIAC's action, its goals were probably somewhat different from OrSFL's.

Aside from bad feelings, nothing came of SIAC's letter. If it was behind the letter, OrSFL was un-thwarted: the federation would have another chance to try to disable the hospital associations a few months down the line when the governor convened a Committee of Fifteen on Revision of the Compensation Law. Along the lines of the original workmen's compensation compromise, the committee consisted of five representatives of employers; five representatives of labor, all of whom were OrSFL-affiliated; and five representatives of the general public, including Dr. Thorald

⁸⁸ Not only was the National Hospital Association a regular advertiser in the magazine, but *Oregon Voter* also made its stance on the hospital association issue very clear in its articles.

⁸⁹ "Suggestion Unpopular," *Oregon Voter*, p. 341

⁹⁰ *Ibid.*, p. 343.

Thoraldsen, who would later become both president of the Multnomah County Medical Society and an affiliate of the National Hospital Association.⁹¹ The committee's main purpose was to recommend a package of revisions to the workmen's compensation system for the 1921 legislative session to consider. Included on the agenda was the contentious hospital association issue.⁹²

The State Industrial Accident Commission set the agenda when the Committee of Fifteen first met on July 19, 1920. Regarding the hospital association issue, SIAC instructed the committee to consider what it thought to be labor's three main complaints about the existing system. First, labor complained about the lack of choice employees faced in selecting their physicians. Second, the payment of monthly fees in a single installment angered those transient workers who moved from camp to camp. Finally, labor lacked a voice in the selection and establishment of medical aid plans. Industrial Accident Commission Chairman William Marshall advised the committee, "If any changes are to be had through legislative action, we believe they will come only through recommendation of your body, if we can judge by the experience of past legislative sessions."⁹³ A bill endorsed by the public, labor, and industry might not suffer the same fate that House Bills 286 and 287 faced in 1919.

⁹¹ For information on the original workmen's compensation compromise, see: Lawrence Friedman and Jack Ladinsky, "Social Change and the Law of Industrial Accidents," *Columbia Law Review*, 1967, vol. 67, pp. 50-82.

⁹² "Restoration of State Aid Proposed," *Oregon Voter*, Vol. 22, No. , July 24, 1920, p. 160.

⁹³ *Ibid.*, p. 169.

When the committee reconvened in August, it determined that the hospital association issue was controversial enough to warrant the appointment of a three-member subcommittee. Thoraldsen was chosen as the public representative, with B.W. Sleeman and B.C. Ball as the labor and industry representatives, respectively.⁹⁴ The subcommittee reported back to the larger Committee of Fifteen on September 13, 1920, and its recommendations did not favor the labor stance. The subcommittee's report, as reproduced in *Oregon Voter*, stated, "There seems to be no doubt that the majority of hospital associations have done good and effective work and no condition should be imposed on them which will prevent the continuation of their good work."⁹⁵ Labor's complaints did not completely lack merit, however, and the subcommittee attempted to make two key concessions: Dr. Thoraldsen argued that the employees should be given some voice in the selection of hospital associations, and that individuals should be given the right to choose another physician under SIAC supervision.

Mr. C.C. Bechtold, General Manager for NHA, attacked Thoraldsen's concessions. Most of the anti-hospital association agitation, he claimed, came not from steady workers, but instead "floaters" affiliated with the radical Industrial Workers of the World union. Employers, Bechtold argued, were far more qualified to make decisions about medical service contracts than their employees. In place of Thoraldsen's plan, Bechtold offered one of his own: (1) SIAC would have full supervision over both

⁹⁴ "Progress in Compensation Law Changes," *Oregon Voter*, Vol. 22, No. , August 14, 1920, pp. 331-332.

⁹⁵ "State Insurance is Labor Objective," *Oregon Voter*, Vol. 22, No. , Sept. 18, 1920, p. 564.

contract and non-contract plans; (2) both contract and non-contract plans would be recognized; (3) SIAC would be in charge of regulating contracts and formulating rules; and (4) employees leaving their employers before the end of the month would receive certificates to transfer the remaining value of their monthly contribution to their next employer.

The committee's labor delegates did not respond well to Bechtold's proposal, and charged that it did nothing to eliminate the hospital associations' profit motives. Frank Hannan, one of the five labor representatives on the committee declared, "State insurance is what we favor... then our troubles are over," clearly aligning himself with the stance SIAC took in its January, 1920 letter. The committee, however, did not take Hannan's suggestion, and instead adopted Dr. Thoraldsen's compromise proposals.⁹⁶

In response to the August meeting, OrSFL's executive board issued its own recommendations. The board backed up Hannan's stronger approach. In its specific comments on the law, it proposed that SIAC be put fully in control of medical, surgical, and hospital care for injuries, and that medical care for occupational injuries "not be subject to contract." In this proposal, the board also indicated that it would allow hospital association contracts for non-occupational medical service, but that such a contract would only be permitted when the workers approved it on a majority vote.⁹⁷ In another statement, issued at approximately the same time, the board stated, unequivocally, that

⁹⁶ Ibid., p. 44.

⁹⁷ "Compensation Law Amendments Sought by Organized Labor," *Oregon Voter*, Vol. 22, No. Nov. 13, 1920, p. 461.

“all contract hospitals and contract doctors be eliminated and prohibited.”⁹⁸ Ultimately, the Committee of Fifteen accepted neither version of the board’s proposal, instead incorporating Thoraldsen’s proposal into its final recommendation. Perhaps as a minor concession to labor, however, the committee’s proposal did call for collection of dues on a daily, rather than monthly basis.⁹⁹

The committee’s proposal was not met with much acceptance by NHA. In a January 1, 1921 editorial, Bechtold castigated the proposal’s per diem and voting requirements. Daily deductions, he argued, would be costly due to the extra clerical work involved. In fact, according to Bechtold, the workers preferred the monthly payment system! The employees were also incapable of selecting their own doctors or associations. Borrowing an often-trumpeted phrase from the medical societies, Bechtold predicted that “it would result in constant solicitation of the employees.”¹⁰⁰ Of course, solicitation’s real threat was not to the medical profession, but rather to the workers’ productive capacities. Despite his opposition to some of the specific provisions, however, Bechtold did accept regulation of the hospital associations.

The proposal also failed to gain the support of the Oregon logging industry, which appears to have been one of the leading voices in the state legislature on the hospital association issue. The *Oregon Voter* magazine reported that “some of the loggers were

⁹⁸ “Kay Insists Upon Compensation Economy,” *Oregon Voter*, Vol. 22, No. , p. 445.

⁹⁹ “Favors Rewards and Penalties for Safety,” *Oregon Voter*, Vol. 22, No. , Dec. 11, 1920, pp. 699-700

¹⁰⁰ C.C. Bechtold, “Society’s Duty Toward the Injured or Sick Workers,” *Oregon Voter*, Vol. 22, No. , Jan 1, 1921, p. 22.

obdurate, feeling that for their isolated camps practical abolition of hospital associations and contract doctors would result in lack of care for injured workmen...”¹⁰¹ The magazine predicted that this minority would mount a fierce fight in the legislature, and probably with some chance of success: Representative Thomas B. Kay, both a member of the Committee of Fifteen, and also the powerful House Committee on Labor and Industries, might have a chance to amend the bill in committee, or simply to kill it outright.

The Committee on Labor and Industries ultimately took the responsibility of introducing the hospital association proposals as House Bill 189. The text of the bill that the committee introduced, and the action that it took, suggests that the proposal’s opponents used the committee system to kill the legislation. First, the committee made substantial modifications to the original proposals. Second, the bill’s opponents used the committee’s status as a vetogate to table the bill.

When H.B. 189 received its first reading on January 28, 1921, listeners might have noted how remarkably different it was from the proposals put forth by the Committee of Fifteen. Most notably, it omitted the majority vote requirement for approving new hospital contracts. In place of the employees’ secret ballot, the H.B. 189 declared that the contracts would be legal provided that they were formulated “in such a manner as the state industrial accident commission may find and determine to

¹⁰¹ “Compensation Law Committee Makes Final Report,” *Oregon Voter*, Vol. 22, No. , Jan. 15, 1921, p. 213.

reasonable...”¹⁰² The bill also deleted the per diem payment basis from the original proposal: hospital contract fees would continue to be collected at the beginning of the month in a single payment. Even these changes would not have placated the bills’ opponents. House Bill 189 contained a provision from the original proposal which made the hospital associations financially liable for recurring conditions. To enforce this provision, the bill allowed SIAC to cancel non-compliant hospital associations’ contracts.

Following its reading, the House referred the bill to the Committee on Labor and Industry. The committee wasted little time, and produced a majority report recommending that the bill not pass on February 9. Representatives Lynn and J.N. Johnston produced a minority report which would have made the bill stronger from OrSFL’s perspective. This report was hardly enough to overcome the opposition of Representatives Kubli, Kay, and W.T. Gordon, and on Kubli’s motion, the majority report was adopted and the bill was indefinitely postponed.

The 1921 legislative session’s outcome had two important consequences. First, it very clearly demonstrated that even with the support of a governor-appointed committee, anti-hospital association legislation had little chance of passing. The bill’s opponents skillfully used their majorities on key committees to kill proposals to limit the associations’ activities. The failure of H.B. 189 through death-by-committee probably lent credence to a belief expressed two years earlier at OrSFL’s 1919 convention. When the convention first discussed Industrial Accident Commissioner Marshall’s proposal for

¹⁰² Oregon. House. *House Bill No. 189*. Thirty-First Legislative Assembly Regular Session, Jan. 28, 1921, p. 1

the governor to appoint the committee of fifteen, Federation Secretary E.J. Stack skeptically remarked that only through initiative and referendum would labor find any relief from the conditions they faced under the workmen's compensation system.¹⁰³ In fact, OrSFL would rely on the initiative approach when it made its next move.

Second, the legislative session revealed the Oregon State Medical Society's declining influence over the hospital association issue. In the past, OSMS had worked closely with OrSFL to gain traction on the hospital association issue. The medical society, however, was noticeably absent from *Oregon Voter's* coverage of the Committee of Fifteen's activities. This absence was not an accident on the reporter's fault. Only one report on the committee's activities appeared in *Northwest Medicine*, and its tone suggests that the medical society watched the formulation of the legislation from afar.¹⁰⁴ Although Dr. Thoraldsen was both a member of the medical society and the Committee of Fifteen, his views may not have been exactly in line with the medical society's evolving policy on contract practice. Some fifteen years later, he would resign from the Multnomah County Medical Society over his affiliation with the National Hospital Association, and his proposals to the committee largely served to preserve the hospital association system.

¹⁰³ Oregon State Federation of Labor. *Year Book for Nineteen Hundred Twenty*. (Portland: Jolly-Ratelle, Printers, 1920), p. 37.

¹⁰⁴ The report reads, "A committee appointed to draft a proposed amendment to the Industrial Compensation Act will present a plan before the next session of the legislature, permitting an injured employee the privilege of choosing his physician or surgeon. A method will be devised by which such a right will be given the employee." ["Medical Notes," *Northwest Medicine*, Vol. 19, No. 10, October 1920, p. 270.]

Extra-Legislative Attempts to Eliminate the Hospital Associations and the Collapse of the OrSFL-OSMS Coalition

The Oregon legislature continued to hear anti-hospital association bills proposed after 1921. In 1923, for example, Senator Charles Hall of Coos County proposed Senate Bill No. 142. This bill would have made the deduction of hospital fees unlawful in all circumstances, except when sixty percent of a business's employees petitioned for that business to enter into a contract "with a certain physician or physicians" for the provision of medical aid.¹⁰⁵ The Hall bill certainly would have satisfied the demand that OrSFL made during the Committee of Fifteen's 1920 meetings for employee voice in the selection of hospital plans. It also may have satisfied the medical society's opposition to hospital associations, for the bill explicitly permitted only contracts with individual physicians or groups of physicians. Hospital associations were usually business groups which hired physicians, and so any contract with a hospital association would not satisfy the bill's requirements. Neither the state medical society nor the OrSFL was probably the driving force behind the bill, however.

According to *Oregon Voter's* analysis, the Hall bill arose out of a Coos County-centered conflict between a group of physicians who failed to secure hospital contracts, and Dr. George E. Dix, who had for some time kept the largest contract with the Coos Bay Lumber Company. The doctors who were excluded from the contract system took

¹⁰⁵ Oregon. Senate. Senate Bill No. 142, Thirty-Second Legislative Assembly, Regular Session, Feb. 1, 1923.

advantage of volatile labor conditions to encourage complaints against Dr. Dix.¹⁰⁶ After a SIAC investigation turned up nothing negative about Dix's practice, the doctors hired a solicitor to circulate a petition requesting the abolishment of the contract system. The Hall bill was the result of this petition.¹⁰⁷

Hall's bill quickly died in committee. On February 15, 1923, the Senate Committee on Industries issued a majority report, signed by four of the committee's five members, recommending that the bill not pass. Senator Hall was the sole author and signer of his minority report, and following the adoption of the majority report, the bill was indefinitely postponed.¹⁰⁸ The bill's death was no loss to OrSFL, however. By this time, the federation had adopted its new strategy of taking the hospital association dispute directly to the people. Ultimately, this approach would prove no more successful than pursuing claims in the legislature, and it would open a rift between OrSFL and OSMS which would only make legislative attempts more difficult.

In September, 1923, OrSFL took its first steps toward fulfilling its goal of creating a state insurance system when it passed a resolution asking Oregon Governor Pierce to appoint a committee to consider changes to the workmen's compensation system. At the committee's first meeting, Commissioner William Marshall expressed his

¹⁰⁶ Incidentally, Wincent [sic] Smith of *Smith v. State Industrial Accident Commission* was a patient of Dr. George E. Dix. Nothing in the trial court transcripts indicates that Smith's case was definitely part of the Coos Bay situation. The connection does seem highly probable, though.

¹⁰⁷ "Contract M.D. System," *Oregon Voter*, Vol. 40, No., Jan. 17, 1925, pp. 202-204.

¹⁰⁸ State of Oregon. Journals of the Senate and House of the Thirty-Second Legislative Assembly. Salem, Oregon: State Printing Department, 1923, p. 179.

goal of creating a compulsory compensation act. Under the then-current system, employers sought out the cheapest rates, and employees suffered as a result. The solution, Marshall argued, was to eliminate the casualty insurance companies' roles in the workmen's compensation system, and to require all companies covered under the act to insure with SIAC.¹⁰⁹

The coverage of the committee's meetings in *Oregon Voter*, *Northwest Medicine*, and the *Oregon State Federation of Labor Yearbook* does not clearly reveal its activities. Briefs published in *Oregon Voter*, opposing the committee's proposals, argued that the workmen's compensation fund should not be political. Under an exclusively state-managed fund, politics would interfere with the efficient management of the fund, a Special Committee from the Portland Fire Insurance Exchange and Insurance Federation of Oregon argued.¹¹⁰ Although the revision committee's opponents may have exaggerated their claims, the committee probably did pursue Marshall's goal of a monopolistic state fund and the elimination of the casualty insurance companies from the market.

Even without transcripts of the committee's proceedings, one thing is clear: the committee was completely unsuccessful at producing any recommendations for change. Regarding the committee's activities, an article in *Northwest Medicine* stated that it "was

¹⁰⁹ "Making Act Monopolistic," *Oregon Voter*, Vol. 35, No. 12, Dec. 22, 1923, pp. 374-378.

¹¹⁰ "Brief and Argument in Opposition to Monopolistic State Insurance of Workmen's Compensation," *Oregon Voter*, Vol. 36, No. 10, March 8, 1924, pp. 301-318.

found impossible to agree on any proposed measure.”¹¹¹ The degree to which physicians were actually included in the committee’s activities is a matter for debate.¹¹² The *Northwest Medicine* report, however, seems accurate on this point: the committee produced no recommendations.

Ultimately, OrSFL took the matter into its own hands, and presented the matter to the people as an initiative petition for the November, 1924 general election. Through amending the Oregon State constitution, the petition aimed to achieve several labor goals. Most important for the hospital associations was the measure’s third paragraph, which stated, “It is unlawful for any employer to contract for, deduct from, or receive any money for contract doctors, or medical, surgical, or hospital attendance or attention...” Under narrow circumstances, the amendment exempted from its rules isolated work camps which would otherwise receive no medical support. The measure’s most controversial provision, however, was its expansion of SIAC powers: the initiative authorized SIAC to make all rules and regulations necessary to enforce it. Furthermore, any legislative attempt to overturn a SIAC ruling would automatically go to the people on referendum. This rule reflected OrSFL’s skepticism of the legislative process, and its

¹¹¹ “Is it State Medicine?” *Northwest Medicine*, Vol. 23, No. 9, Sept., 1924, p. 419.

¹¹² *Northwest Medicine* described the conference as including representatives of labor, industry, and medicine. [“Is it State Medicine?” p. 419] *Oregon Voter*, however, reported that the committee included representatives of employers, employees, and the general public, exactly along the same lines of the 1920 committee and the group that drafted the original 1913 workmen’s compensation act. [“Making Act Monopolistic,” p. 374.] Furthermore, the OrSFL Executive Board pointed out that the physicians were not invited to participate in the conference at all. [Oregon State Federation of Labor, Year Book for 1925, 1925, p. 18]

hope that it could achieve its goals through initiative petition. It also, however, played a significant part in the measure's November death.

Oregon's voters resoundingly defeated the measure when it appeared on the November 4, 1924 ballot. The Secretary of State reported only 73,370 votes in favor of the initiative, compared with 151,862 against.¹¹³ The OrSFL's loss hardly came as a surprise: two days before the election, *The Oregonian* predicted the measure's defeat. The chief argument against the measure, according to the newspaper, was that "the proposed amendment will place the whole responsibility in the hands of three political appointees, responsible to no one except the governor who appoints them and they cannot even be curbed by the legislature."¹¹⁴ The hospital associations' opponents would not be able to defeat contract medicine through legal means outside of the state legislature.

The November 4th loss had another important consequence: the OrSFL's new strategy decimated its tentative coalition with OSMS. The state medical society did not actually completely oppose the measure. According to an editorial in *Northwest Medicine*, many parts of the amendment were good. The problem, however, was that it contemplated a substantial extension of the industrial insurance act to all citizens of the state. Thus, the amendment was actually "a wedge for the establishment of state medicine, with all its objectionable features..."¹¹⁵ The Oregon Public Health League's

¹¹³ State of Oregon. *Blue Book and Official Directory, 1925-1926* (Salem: State Printing Department, 1925), p. 53.

¹¹⁴ "Muddy Campaign Closes in Oregon," *The Oregonian*, Nov. 2, 1924, p. 10, col. 1.

¹¹⁵ "Is it State Medicine?" *Northwest Medicine*, Vol. 23, No. 9, Sept., 1924, p. 419.

statement on the measure confirms that the medical profession opposed it over concerns about state medicine.¹¹⁶ According to the League, the amendment would “declare the social concept to be that compensation for work accidents, adequate medical and surgical service, and vocational rehabilitation is peculiarly a function of the state and **not a business for private profit** [sic].”¹¹⁷ The League’s statement was hardly a ringing endorsement of the hospital associations’ method of doing business. The associations and the medical societies, if only temporarily, found some limited ideological common ground over the issue of state involvement in the market for medical services.

The injury to the OSMS-OrSFL coalition went beyond the issue of state medicine. At the OrSFL’s 1924 convention, the federation’s executive board expressed its anger over the medical society’s opposition to the measure. The “principal reason given by them,” the board declared, “was that representatives of the medical profession had not been called into conference by the governor when his committee was appointed, and had not been consulted later when the amendment was drafted.”¹¹⁸ The medical society gave a different explanation, but whatever the true reason was, the hospital association issue devolved into a struggle between the two groups. No longer enjoying the medical

¹¹⁶ The Public Health League was a separate body from the Oregon State Medical Society. The two organizations drew from the same general body for members, and according to *Northwest Medicine*, the league was “a vital factor in the medical and health considerations of the states of the Pacific Northwest.” [“The Oregon Plan for the Public Health League,” *Northwest Medicine*, Vol. 23, No. 9, Sept., 1924, p. 419]

¹¹⁷ “Public Health Leagues: Oregon,” *Northwest Medicine*, Vol. 23, No. 9, Sept., 1924, p. 436.

¹¹⁸ Oregon State Federation of Labor, *Year Book for 1925*, 1925, p. 18.

society's support, OrSFL turned to their irregular rivals, the Oregon State Association of Naturopaths, Inc. (OSAN)

The naturopaths were quick to exploit the OrSFL-OSMS division to gain traction in their own fight against organized, regular medicine. Dr. Henry Collins spoke for OSAN at the OrSFL convention in 1924, attempting to enlist support for another bill on the November ballot, which would give naturopaths full rights as licensed physicians.¹¹⁹ Collins declared, "Our training, as you will notice, is as good as the surgeon, but the surgeon has his place. We have ours... We only desire an equality of privileges that you have."¹²⁰ Collins' speech was well-received by the delegates, who, in their search for new partners, passed a resolution calling for the passage of the Naturopath Bill. Immediately before the vote on the resolution, a delegate compared the medical profession to the Standard Oil Company: "This is one of the biggest combinations in the country—this medical profession," the delegate declared.¹²¹ The resolution to support the Naturopath Bill passed with only one vote in opposition.

The Naturopath Bill, like the workmen's compensation amendment, failed on November 4, 1924. Thus, by the end of 1924, OrSFL had failed to eliminate the hospital associations through both the legislative process and initiative petition. Furthermore, it had destroyed the tentative coalition which had previously existed between it and OSMS.

¹¹⁹ For more information on the "Naturopath Bill," see: "Naturopath Bill," *Oregon Voter*, Vol. 39, No. 5, Nov. 1, 1924, pp. 25-26.

¹²⁰ Oregon State Federation of Labor, *Year Book for 1925*, 1925, p. 32.

¹²¹ *Ibid.*, p. 46.

The coalition had been unable to bring about change in the legislature, but without it, neither group stood a significant chance at eliminating the hospital associations.

Following the 1924 debacle, the hospital association largely disappeared from the agendas of both the state legislature and OrSFL for the next several years. A slight exception to this was a set of hearings on workmen's compensation under State Senator Gus Moser between 1926 and 1927. The federation was not enthusiastic about the Moser committee to begin with. The OrSFL executive committee reported, "After having conferred with members of the Industrial Accident Commission..., we decided not to call a conference, as it was feared that the desired results could not be obtained under present conditions."¹²² Thus, when the 1925 legislative assembly appointed the committee under Concurrent Resolution No. 14, OrSFL was skeptical of the potential results.¹²³ Nevertheless, OrSFL did make a request at the committee's hearings for an exclusive state fund and the elimination of contract practice. The medical society did not back OrSFL up at all: it recommended no drastic changes, and merely suggested that SIAC appoint an advisory committee including at least three physician members.¹²⁴ The

¹²² Oregon State Federation of Labor, *Year Book for 1927*, 1927, p. 7.

¹²³ Oregon State Federation of Labor, *Year Book for 1927*, 1927, p. 7; Oregon. Legislative Workmen's Compensation Committee of the State of Oregon. *Report of the Legislative Workmen's Compensation Committee of the State of Oregon*, 1927, Oregon State Archives. Accession.

¹²⁴ *Ibid.*, pp. 104-105, 190-196.

committee limited its final recommendations to budgetary matters, and issued no recommendation concerning hospital associations.¹²⁵

Conclusion

As the prosperity of the 1920s ended and the Great Depression commenced, any realistic hope of resolving the hospital association issue through the legislative process was gone. Several factors had contributed to this. First, the structure and rules of the legislature thwarted any attempts at reform by the anti-hospital association forces. In both 1919 and 1921, individual committees killed legislation that might otherwise have passed. In 1919, for example, H.B. 445 passed the House with a clear majority before Senators Smith and Wood played key roles in eliminating it in committee. Second, the constantly-shifting anti-hospital association coalition demonstrated significant lack of internal agreement over key issues. For example, labor interpreted free choice of physician to mean freedom to choose *any* medical practitioner. The difference between organized medicine and organized labor on this point became clear when OrSFL chose to support the naturopaths in the 1924 general election. Furthermore, any cooperation between OrSFL and the insurance companies must have eroded in that same election. The insurance companies probably played a role in the 1919 legislative battles, but they certainly would not have partnered with OrSFL after 1924. Third, the substantial lack of unity within the medical profession would have made organized medicine an ineffective partner for OrSFL even had the naturopath bill not come between the two groups.

¹²⁵ Ibid., pp. 1-5.

Contract doctors' participation in the medical society's policy formulation efforts during the 1920s contributed to its inability to articulate and defend clear stances, especially when those same contract doctors were members of the Oregon legislature. These three factors multiplied together to create a situation in which the hospital associations' opponents really could not upset the 1917 arrangements that they so bitterly detested.

Over the decade, the anti-hospital association forces had become aware that the legislature was not the only venue for resolving their complaints. In 1924, OrSFL went directly to the people, albeit unsuccessfully. Those labor groups outside of the AFL did not enjoy the same level of access to the formal political process, and necessarily used other tactics. Senator Hall's statements in the Moser Committee meetings alluded to this. Referring to the monthly collection of fees, he stated, "[T]his is a practice that is causing very considerable irritation and contributes very largely to radicalism and that sort of thing among employes."¹²⁶ Extra-legislative efforts had yet to prominence by 1929. Not long after, however, the Oregon State Medical Society would adopt a strategy of attempting to resolve the hospital association issue in the private sector.

¹²⁶ Oregon. Legislative Workmen's Compensation Committee of the State of Oregon. *Report of the Legislative Workmen's Compensation Committee of the State of Oregon*, p. 73.

CHAPTER III

THE PRIVATE SECTOR SOLUTION: THE OREGON STATE MEDICAL SOCIETY
CONFRONTS CONTRACT MEDICINE, 1931-1936

Evidently the human mechanism is not fitting into the processes of the assembly line in such a way as to produce the best results. It may seem unkind that we have here another example of the layman's confusions and contradictions when he attempts to combine his medical knowledge with his social and economic knowledge.

– Bureau of Medical Economics, American Medical Association, 1935

If corporate responsibility is to be barred from contributing to the solution of the problems involved in the cost of medical care for all the people, the trend will fix itself, we fear, towards what doctors fear most – Social Medicine, with its potentialities for evil.

– *Oregon Voter Magazine*, 1936

As the 1930s opened, the Oregon State Medical Society seemed to pick up the contract medicine issue where the Oregon State Federation of Labor had left off. With OSMS as the new leading player, the debate changed dramatically. In the 1920s, the question was one of how much regulation the hospital associations would be subject to, and which public regulatory body would be responsible for overseeing contract medicine. As the medical societies imposed their new strategy, however, the issue became not one of how regulation would be shaped in the public sphere, but instead one of whether the prepaid medical services market would be regulated by public statutes or private codes.

Medical Ethics and the Challenges of the 1930s

Medical societies entered the 1930s profoundly aware of contract medicine's challenge to their professional position. This challenge prompted the American Medical

Association to produce series of studies on the ethical issues behind group payment plans. In addition, the AMA cooperated with other groups to survey the new economic terrain. Most famously, the Committee on the Costs of Medical Care, a group of leading physicians, public health specialists, and economists organized in 1927, collaborated with the National Bureau of Economic Research to make a study of “the extent to which the people of the United States make use of the principle of insurance in order to secure medical and hospital care.”¹²⁷ The collaboration resulted in a widely-cited 1932 volume, *The Purchase of Medical Care Through Fixed Periodic Payments*, identified as one of the first reports to discuss organized payments for medical services and to review then-current approaches.¹²⁸

Why did the medical profession become so interested in the ethics of medical payment plans in the 1930s? The AMA studies suggest a few related explanations. First, the period saw the emergence of new forms of contract practice. In 1932, the NBER determined that most group payment plans were restricted to lumber, mining, and railroad camps. Group payment and contract medicine grew “out of the isolation of the communities in which workers live.”¹²⁹ Despite contract medicine’s relative isolation, however, the NBER noted that private group clinics, community health associations, non-

¹²⁷ Williams, Pierce. *The Purchase of Medical Care Through Fixed Periodic Payment* (National Bureau of Economic Research, 1932), v., accessed at <http://www.nber.org/books/will32-1>.

¹²⁸ See, for example: Bureau of Cooperative Medicine. “New Plans of Medical Service: Examples of Organized Local Plans of Providing or Paying for Medical Services in the United States,” (New York City, 1940), p. 3.

¹²⁹ Williams, p. 2.

profit community hospitals, and medical benefit corporations had begun to emerge in urban areas. A 1939 AMA study, *Organized Payments for Medical Services*, also dated the beginnings of urban group hospitalization plans around the end of 1931.¹³⁰

Second, the Great Depression itself created a renewed interest in sickness insurance. According to *Organized Payments*, while public interest in sickness insurance “seemed to have almost disappeared” during the 1920s, it was “more acutely aroused after the industrial crisis of 1929 and the succeeding severe depression.”¹³¹ For example, hospitals which overextended themselves in the 1920s adopted prepayment plans as a means of dealing with the vastly increased demand for free services by poverty-stricken patients.¹³² The AMA also identified the federal government’s response to the Depression as a related factor in promoting contract medicine. The medical societies believed that they had been on the verge of victory over contract medicine in 1933. “The criticism directed by organized medicine against contract doctors,” *Organized Payments* claimed, “were so thoroughly supported by factual data... that there was little objection in most cases to its abolition.”¹³³ The federal government’s involvement in local relief,

¹³⁰ American Medical Association. Bureau of Medical Economics. “Organized Payments for Medical Service.” (Chicago, Illinois, 1939), p. 154.

¹³¹ *Ibid.*, p. 13.

¹³² *Ibid.*, p. 18.

¹³³ *Ibid.*, p. 33.

however, resulted in “renewed attempts to restore contract poor doctors as part of the medical machinery of relief.”¹³⁴

Third, the expansion and urbanization of contract medicine represented a direct challenge to the medical societies. The NBER, allegedly taking a neutral stance, argued that the new urban plans “[q]uite definitely [represented] attempts to modify the traditional basis of medical economics.”¹³⁵ A 1935 AMA report, *Medical Relations Under Workmen’s Compensation*, spelled out in detail how this attempt to modify the traditional basis of medical economics worked. Originally, contract medicine had filled an unmet need: medical professionals did not serve the isolated logging, mining, and railroad camps. Thus, companies made medical contracts to serve their workers’ occupation-specific medical needs. The medical societies, of course, had criticized company-hired contract doctors on many counts, but not until they “steadily and almost stealthily” left the isolation of the camps to enter the “great cities” did they pose a serious challenge to organized medicine. As contract medicine assumed its new urban role, it expanded beyond the provision of first aid, accident prevention, and employment examinations to provide complete medical services to families. This expansion, the AMA argued, “brought the industrial physician into sharp and subsidized competition with the private practitioner and led to bitter conflicts in many localities.”¹³⁶ The medical

¹³⁴ Ibid.

¹³⁵ Williams, p. 216.

¹³⁶ American Medical Association. Bureau of Medical Economics. “Medical Relations Under Workmen’s Compensation.” (Chicago, Illinois, 1935 Revision), p. 122.

societies, therefore, probably developed their strong interest in the ethics of contract medicine in response to the economic challenges it posed to organized medicine.

The AMA's main point of attack, however, was not on contract medicine's economic challenge to society physicians, but rather its *ethical* problems. In a 1932 article in the *Journal of the American Medical Association*, for example, R.G. Leland framed the problem as purely ethical. Contract medicine, he conceded, was not new, but it was expanding and assuming new forms using unethical approaches. Ethically-sound contract medicine was possible, but its soundness depended on its administrative integrity and the motives underlying its operation.¹³⁷ These requirements, of course, were rarely met, and the AMA was quick to point out the contract doctors' failings. The AMA singled out Oregon and Washington contract medicine in particular in *Medical Relations*: "In Washington and Oregon, at least, contract practice, centering around compensation, has developed to a point where it threatens at once the economic and the ethical foundations of the profession."¹³⁸

Organized medicine summarized the profession's "ethical foundations" in the *Principles of Medical Ethics of the American Medical Association*, first proposed in 1847. The *Principles* underwent substantial revision between 1847 and the 1930s, but its fundamental idea remained the same: the primary goal of medicine was service to humanity, not profit. The *Principles'* other provisions grew out of this idea. For example,

¹³⁷ R.G. Leland, "Contract Practice." (Reprinted from JAMA, March 5, 1932, Vol. 98, 808-815), pp. 1, 3.

¹³⁸ American Medical Association. Bureau of Medical Economics. "Medical Relations," p. 133.

the profession rejected sectarian knowledge because it restricted inquiry, and in doing so compromised the quality of medical care: “The channels by which new ideas increase the general fund of medical knowledge should not be narrowed by sectarian theories,” the AMA argued in its 1936 pamphlet, *Economics and the Ethics of Medicine*.¹³⁹ Similarly, the *Principles* prohibited doctors from accepting rebates on prescriptions and surgical appliances: physicians’ judgments should not be financially-based, but instead centered around delivering the highest-quality care possible to the patient.¹⁴⁰

Behind the anti-rebate provision lay another, closely-related principle: if the medical provider’s financial interests came to the surface, the patient’s confidence in his or her physician would be destroyed, potentially delaying or preventing recovery.¹⁴¹ The patient-physician relationship, the AMA held, was paramount. Thus, medical ethics required that the patient have free choice “among equally qualified” physicians. Free choice would advance the individual patient’s interests through heightened confidence in the physician, but it would also benefit society: through competition in which quality of care was the sole measurement, the best physicians would float to the top, ultimately advancing the entire profession.¹⁴² Perhaps the medical ethics of the 1930s was best summarized by three words: *quality, not cost*.

¹³⁹ American Medical Association. Bureau of Medical Economics. “Economics and the Ethics of Medicine.” (Chicago, Illinois, 1936) p. 16.

¹⁴⁰ *Ibid.*, p. 31.

¹⁴¹ *Ibid.*

¹⁴² American Medical Association. Bureau of Medical Economics. “Medical Relations,” p. 66.

Contract medicine generally failed the test of medical ethics on three counts. First, it distorted the patient-physician relationship. Patients were often assigned to physicians without any personal choice in the matter. This lack of choice, the AMA claimed in *Organized Payments*, tended “to destroy the value of the information necessary for good medical care.”¹⁴³ The obvious result would be delayed recovery and indirect injury to the patient. In addition to restricting free choice, contract medicine introduced a third party into the patient-physician relationship. Hospital associations, R.G. Leland argued in 1932, were really business offices that employed physicians: “It is not uncommon for these czaristic adjusters to dictate to physicians the extent to which their services shall go in an individual case.”¹⁴⁴ Contract medicine often went against the principles of medical ethics by interfering with the decisions which should have been made between the patient and the physician.

Contract medicine’s second flaw was its failure to carry out the fundamental idea behind medical ethics: contract medicine did not promote public welfare. Through its original exclusion of non-contract physicians from the care of injured workmen, contract medicine slowed the development of occupational health as a field of medicine. Contract medicine also divided the medical profession. The division weakened the medical profession politically, preventing it from effectively lobbying the legislature on workmen’s compensation matters. If the situation further deteriorated, the AMA warned

¹⁴³ American Medical Association. Bureau of Medical Economics. “Organized Payments,” p. 32.

¹⁴⁴ Leland, p. 4.

in *Medical Relations*, America might go the way of Europe: “In the European experience, the economic organization, no longer backed by a united profession, became more and more helpless to defend itself against the encroachments of “business necessities” until it was almost the literal slave, economically and scientifically, of business interests.”¹⁴⁵ A business-dominated medical system would hardly be in the public interest, the AMA posited.

The third flaw behind contract medicine was indeed its emphasis on business-type measurements instead of the quality measurements preferred under the Principles of Medical Ethics. The AMA’s opposition to advertising and solicitation, which the hospital associations unabashedly used, illustrates this point well. “The effectiveness of medical advertising,” the AMA wrote in *Economics and the Ethics of Medicine*, “is not judged by the quality of the service but by the number of patients attracted by the advertisement.”¹⁴⁶ Medical ethics accepted competition as absolutely vital to medical advancement, but this competition had to be based on the actual quality of the care provided. Advertising distorted the competition by substituting what organized medicine deemed to be the irrelevant factors of cost and number of patients.

Medical ethics very clearly rejected the business world’s emphasis on cost. To what extent, however, did economic factors guide medical ethics? The AMA conceded that cost and compensation of the physician were important concerns, even though they

¹⁴⁵ American Medical Association. Bureau of Medical Economics. “Medical Relations,” pp. 141-142.

¹⁴⁶ American Medical Association. Bureau of Medical Economics. “Economics and the Ethics of Medicine,” p. 19

had to be subordinate to quality and the promotion of the public good. In *Economics and Ethics*, the AMA wrote, “Good medical service cannot be expected unless society appreciates the value of such service sufficiently to reward properly the type of young men who can and will give good service. But it is equally true that a profession that seeks first financial reward will lose its survival value and perish.”¹⁴⁷ Economics and ethics, in other words, enjoyed a tangled relationship to one another. The promotion of the public good would be impossible without at least some attention to medical costs and physician incomes.

The medical societies’ approach to indigent care illustrates the AMA’s complicated relationship to economic and business matters. In *Organized Payments*, the AMA defined “indigents” as “those who have been declared by some public or private investigating body as being incapable of providing themselves with the essentials of life.”¹⁴⁸ Long before the 1930s, the Principles of Medical Ethics declared that physicians had a professional obligation to provide gratuitous care to the indigent. The profession hardly welcomed contract medicine’s attempts to share in this responsibility after 1932, however. Contract medicine, the AMA claimed, unduly restricted the indigents’ “choice of a physician chiefly because of their economic status.”¹⁴⁹ Under physician-provided

¹⁴⁷ Ibid., p. 11.

¹⁴⁸ American Medical Association. Bureau of Medical Economics. “Organized Payments,” p. 28.

¹⁴⁹ Ibid., p. 32.

care, of course, those unable to pay would still be able to choose among all of the local medical society's upstanding and responsible members.

The issue, however, was not purely an ethical one. When medical societies eventually developed their own payment plans, they included filtering mechanisms to ensure that only low-income patients received services. The Medical-Dental Service Bureau, established in early 1935 in Delaware and Washington, D.C., included such a filtering mechanism. The Bureau only exercised administrative responsibilities: it investigated each new patient's economic status, determined his or her ability to pay, and worked out an installment plan to collect the bills. It also accepted patients referred by the Central Admitting Bureau for Hospitals, "a filter system to determine the economic status of persons deserving free hospital services."¹⁵⁰ In line with medical ethics' prohibition on advertising, the Bureau did not advertise or make any attempt to contact prospective patients. Both the advertising restrictions and especially the filtering mechanism ensured not only that medical society physicians shared equally the financial losses from gratuitous services, but that they also continued to receive payments from the well-to-do, who would be unable to enroll in the less-expensive prepaid plans.

Non-medical-society-sponsored plans earned the AMA's scorn. Even medical groups which provided quality service, R.G. Leland argued, demonstrated antipathy to organized medicine, showed a lack of interest in medical charity, and tried to influence the companies they served to petition the state legislatures to maintain the contract

¹⁵⁰ Ibid., pp. 93-94.

system. “This attitude,” he wrote, “is held by many contract physicians.”¹⁵¹ Furthermore, the medical groups’ low rates implied that the medical profession charged too much.¹⁵² Leland’s writings show that the medical societies were extremely concerned about the economic, and not only the ethical, challenges of contract medicine. By creating divisions among doctors and by not properly sharing in the costs of indigent care, contract medicine cost the profession money.

The medical societies’ approach to indigent care shows just how complicated the ethical-economic problem was. Both the Leland argument and the activities of the Washington, D.C., Medical-Dental Service Bureau demonstrate concerns over cost. However, the Medical-Dental Service Bureau did preserve patient choice of physician, and kept the administrative side of the group out of the patient-physician relationship by restricting its role to only financial matters. Furthermore, had the medical societies completely ignored costs, they would eventually have been unable to serve the public good for want of financial resources.

To claim that organized medicine was only out to make money in the 1930s seems to be a stretch. The medical societies were, however, extremely conscious of protecting their position in society at large. The AMA’s discussion of medical ethics in *Economics and the Ethics of Medicine* shows that the medical societies were extremely aware of the challenges that they faced, and that they accepted the use of medical ethics as be a weapon against their opponents. Every ethical code, the AMA pointed out, was

¹⁵¹ Leland, p. 5.

¹⁵² Ibid., p. 16.

promulgated by a group: “It is the creator and enforcer of ethical standards peculiar to its members.”¹⁵³ An ethical code occupied an important place within any group as the source of its strength and stability: because the greater society’s attitude toward the group depended upon the value the community placed on that group’s service to society, the group needed to maintain a good public image through membership standards. If the medical profession failed to adhere to its code of ethics, business elements might introduce conflicts into the group.

If unable to defend its value to society, the medical profession might eventually go the way of the craft and merchant guilds: “Personal relations between producers and consumers and status within guild organizations became of less importance than commodity relations in exchange and contract relations within the organization of production and marketing.”¹⁵⁴ If the medical societies became subservient to cost and if they allowed medical *businesses* to trample on the patient-physician relationship, eventually society would see no reason to support the professional group’s existence. The medical profession could suffer the same misfortune as the guild organizations: loss of personal control over their product. To maintain economic and professional control over medical services, therefore, the medical societies had to follow the code of ethics.

The code of medical ethics, of course, had a major weakness. In 1926, philosopher Carl F. Taesch pointed out that medical societies themselves actually had

¹⁵³ American Medical Association. Bureau of Medical Economics. “Economics and the Ethics of Medicine,” p. 64

¹⁵⁴ Ibid., p. 69.

very little formal control over medical behavior: the United States legal system had the final say. Compounding the problem further, the average 1920s physician tended to neglect his political and social obligations: “He lets matters run on until election,” Tausch claimed, “or until he becomes interested in a particular program and then discovers how impotent he is in the face of an organized system, the members of which regularly attend ward meetings, hold political caucuses, and swelter in conventions.”¹⁵⁵ If the medical societies hoped to defend their professional terrain, Tausch suggested, they would have to do so through the political and legal systems.

Curiously, the medical societies showed a remarkable lack of interest in defending their position by regulatory legislation through the state legislatures in the 1930s. In *Medical Relations*, the AMA rejected state regulation as the solution to the contract medicine problem: “In spite of [the State of Washington’s] provision for closer regulation, the industrial commission has never seemed to accomplish much in controlling and regulating contract medical practice.”¹⁵⁶ The reason for regulation’s failure to rein in contract medicine? “All the economic motives are against good service,” the AMA argued.

The AMA may have publicly blamed contract medicine’s underlying economic motives. The association’s discussion of workmen’s compensation politics, however, indicates that the AMA recognized its own impotence in the state legislatures. During

¹⁵⁵ Carl F. Tausch, *Professional and Business Ethics* (New York: Henry Holt and Co., 1926), p. 179.

¹⁵⁶ American Medical Association. Bureau of Medical Economics. “Medical Relations,” pp. 129-130.

the workmen's compensation system's formative years, the AMA conceded, the physicians and workers "whose condition was to be most deeply affected by the operation of the compensation system seem to have been largely indifferent to the actions being taken and blind to their possible effects."¹⁵⁷ Even if the medical profession was at fault for failing to adequately participate in the original enactment of workmen's compensation, however, they had little to gain from involving themselves in the amendment process. That process would yield only legislation favorable to "the interests that were involved in the original legislation."¹⁵⁸

If the medical societies rejected political solutions to the contract medicine issue, how would they solve it? A comment in *Economics and the Ethics of Medicine* suggested the answer: "Group solidarity requires some machinery for the adjustment of inevitable disagreements. The legislative and judicial machinery of the state is not suitable for this purpose. The laws the state is formed to enact do not enter into the details of professional ethics and disputes."¹⁵⁹ The medical societies possessed their own machinery and their own code. They would solve the issue in the private sector by forming their own "ethically-sound" group plans to compete with the contract doctors, and by revoking medical society membership from those physicians who failed to adhere to their interpretation of the principles of medical ethics.

¹⁵⁷ Ibid., p. 18.

¹⁵⁸ Ibid., p. 21.

¹⁵⁹ American Medical Association. Bureau of Medical Economics. "Economics and the Ethics of Medicine," p. 41

Founding the Multnomah Industrial Health Association

At the outset of the 1930s, the Oregon State Medical Society demonstrated a fresh interest in what appeared to be political solutions to the contract medicine problem. In his aptly-titled October 1931 address to the society's fifty-seventh annual meeting, OSMS President Dr. Thomas E. Griffith laid out what he perceived as the "Problems Before the State Society." The Great Depression, he argued, put citizens "in a mood receptive to the appeal of the various nostrums and remedies promulgated daily."¹⁶⁰ He referred not to the patent medicines which the profession had been fighting for years, but rather to the system of "paternal or state medicine." Blaming social workers, industry leaders, and philanthropists for their role in promoting the system, Griffith remarked that the rise of commercialized medicine had led to a "barrage of accusations..., the most important of which is that of "the high cost of medical care.'" Almost definitely failing consciously to differentiate contract medicine from state medicine, he remarked that the most serious result of the system's increasing prominence was its material effect on the "economic problems of physicians both individually and nationally."¹⁶¹

Griffith proposed three solutions to the issues that the system created. First, he proposed that medical societies assume an enlarged role in directing the activities of social welfare bureaus. Under the direction of local medical societies, the bureaus could eliminate "the extension of charitable service to individuals able to pay a reasonable

¹⁶⁰ Thomas E. Griffith, "Problems Before the State Society," *Northwest Medicine*, Vol. XXX, No. 12, p. 552.

¹⁶¹ *Ibid.*, p. 553.

fee.”¹⁶² Griffith referred, of course, to the filtering mechanisms later popularized in the AMA’s literature on medical economics. By restricting charitable (and inexpensive) services to only those completely unable to pay, the profession would ensure that it maintained a considerable revenue stream in the depths of the Great Depression.

Second, Griffith cautioned the local medical societies to maintain a unified public front. “By minimizing our internal problems through friendly intercourse and group discussions,” he said, “and by the proper interpretation of our ethical standards and obligations one to another, we will develop a spirit of collaboration and solidarity among our members which will enable us to render logical conclusions in the solution of our major problems.”¹⁶³ Griffith referred to the same problem Carl Tauesch had pointed out in 1926: the medical societies had practically no formal control over physicians. Furthermore, Griffith carefully chose to use the word “proper” in discussing the interpretation of the code of ethics. Quite some time would pass before the medical societies would publicly issue a statement of their policies toward medical payment plans, let alone reach a consensus on the exact application of the code of ethics to the new conditions of the 1930s. Looking ahead in the new decade, however, both the Oregon State Medical Society and their president were acutely aware of how important it would be to reach an internal accord on the contract medicine issue.

Finally, Griffith argued that the state and county medical societies needed to increase their participation in Oregon state politics:

¹⁶² Ibid.

¹⁶³ Ibid.

The county units can render valuable assistance to the State Society in the field of politics. In the past, physicians have been extremely careful to remain aloof from any and all matters relating to politics. However, we are learning that to secure legislative enactments or amendments, we must interest ourselves and, through personal touch with our legislators or possible candidates, ascertain their views upon proposed legislation beneficial to the people of our state and to our profession.¹⁶⁴

On the surface, Griffith's proposal appeared to be public-minded. The state medical society and its constituent county societies would take its problems to the state legislature, where an accord acceptable to the state's citizens could be reached. As it later turned out, however, the state and county medical societies did not clearly accept the compromises inherent to the political process. While organized medicine did come to occupy a powerful position in the state legislature, it relied mainly on private sector solutions to the problem of contract medicine, possibly contravening state public policy.

Not long after Griffith's address, OSMS's constituent county societies began to experiment with their own hospital association plans. This approach to the contract medicine issue was relatively new. An August, 1931 report to the Washington State Medical Society on medical economics described how such a plan might work:

Another plan, yet untried, is a service by organized medicine. Here the county society contracts to take a group at a fixed monthly rate per individual. Doctors are called in rotation or free choice of doctors is extended to the insured group."¹⁶⁵

Individual members of the Multnomah County Medical Society, a local OSMS unit, followed up on this idea shortly thereafter. In February 1933, these members formed the

¹⁶⁴ Ibid.

¹⁶⁵ "Medical Economics: Report of the Committee of Seven," *Northwest Medicine*, Vol. 31, No. 4, p. 203.

Multnomah Industrial Health Association (MIHA). By July 1934, MIHA included 206 physicians, including seven in nearby Washington County. In November of the next year, the association had another 29 physicians and a total of approximately 6,000 subscribers, all of whom had annual incomes at or below \$1800, and many of whom contracted directly with MIHA instead of through an employer. By January 1936, MIHA claimed yet another 1000 subscribers.¹⁶⁶

According to a later editorial in *Northwest Medicine*, the journal of the Oregon, Washington, Idaho, and Pacific Northwest Medical Associations, MIHA's founders intended to achieve several goals. First, the founders attempted to meet the problems of the Great Depression by providing prepayment of medical services for low-income employees. Second, they planned to create an alternative to the lay-owned hospital associations: MIHA would be physician-owned, and its patients would be able to charge from a large panel of physicians, preserving the all-important patient-doctor relationship. Finally, and most importantly, MIHA would allow organized medicine to successfully compete with the proprietary hospital associations: "It was hoped that ultimately the commercial hospital associations, with their solicitation of patients, might be driven from the field."¹⁶⁷ Ultimately, this objective would form the crux of the private market

¹⁶⁶ American Medical Association. Bureau of Medical Economics. "Medical Relations," pp. 61-63; Multnomah Industrial Health Association, "Bulletin No. 7" ; Multnomah Industrial Health Association, "Bulletin No. 13"

¹⁶⁷ "Editorial: The Hospital Association Situation in Portland," *Northwest Medicine*, Vol. 35, No. 8, p. 316.

solution: organized medicine would attempt to meet the challenges of contract medicine not primarily through politics, but instead through economic competition.¹⁶⁸

Oregon and Washington appear to have been on the leading edge in terms of developing physician-controlled contract practices. In a 1940 article for the Federal Security Agency, Louis S. Reed stated that the first medical society plans were established between 1931 and 1933 in Oregon and Washington, and remarked that “until recently they stood alone.”¹⁶⁹ Indeed, OSMS approached MIHA and other local plans exceedingly cautiously. In 1932, the OSMS Committee of the Study of Health and Accident Insurance by the State Medical Society advised that organized medicine stay out of the insurance business on the state level. The local plans would serve as laboratories. “We advise,” the Committee wrote, “that the Council of the Oregon State Medical Society observe these organizations and if successful encourage either a federation or an arrangement for cooperation among the different groups...”¹⁷⁰ The Multnomah County Medical Society (MCMS) was similarly cautious: the society made its endorsement of MIHA contingent upon the association’s acceptance of a set of

¹⁶⁸ Pierce Williams’ 1932 NBER report corroborates this point. He writes, “Increase in the number of private group clinics is evidence of recognition on the part of the medical profession of the need for an improved form of organization for rendering efficient medical service... [M]edical men are supplying valuable experience by which further developments in the field of medical insurance can be tested.” [Williams, p. 31]

¹⁶⁹ Louis S. Reed, *Costs and Benefits Under Prepayment Medical Service Plans* (Federal Security Agency: Social Security Board, Washington, D.C., 1940), p. 2.

¹⁷⁰ “Minutes of the Fifty-Eighth Annual Meeting of Oregon State Medical Society, Sept. 22-23-24, 1932,” *Northwest Medicine*, Vol. 31, No. 12, p. 586.

principles of operation. And for a short time, MCMS remained satisfied that MIHA upheld these principles.¹⁷¹

Problems Arise

Multnomah Industrial Hospital Association's honeymoon was short-lived. According to *Northwest Medicine*'s editorial staff, three factors undermined the association's relationship with MCMS. First, competition with the commercial hospital associations forced MIHA "to advise employers and employees regarding their organization." This, of course, was a blatant violation of the Code of Ethics' prohibition on solicitation. Second, the medical society's council saw a change in membership, and became more hostile to MIHA's activities.¹⁷² Finally, and most importantly, MIHA entered into a contract with Portland-area public school teachers. The contract explicitly limited coverage to those teachers who made at or under \$1800 annually, but many society physicians felt that the income level should have been capped at \$1500.¹⁷³

¹⁷¹ "Editorial: The Hospital Association Situation in Portland." *Northwest Medicine*, Vol. 35, No. 8, p. 316.

¹⁷² The membership changes actually worked both ways. For example, on October 14, 1935, Dr. Banner R. Brooke resigned from MIHA. The next year he would play a critical role in the fight against the association as MCMS president. That year, Dr. Tharald Tharaldson, a former MCMS president, would resign his MCMS membership in protest of the society's treatment of contract doctors. In all likelihood, at least some of the conflict flowed out of discontent with compensation physicians received through MIHA and the proprietary hospital associations.

¹⁷³ Ibid.

In direct response to the MIHA situation, MCMS convened a Committee on the Study of Medical Care for Low-Income Persons under the chairmanship of Karl H. Martzloff. The committee had three principal tasks: (1) to study differences of opinion within MCMS regarding the hospital association issue; (2) to issue recommendations on how to apply the American Medical Association's "Ten Principles" of medical ethics to MIHA; and (3) to consider general issues around low-income medical care. In October 1935, the committee issued what would be commonly referred to in both the lay and medical presses as "the Martzloff report."¹⁷⁴

The committee drew several conclusions from its analysis of MIHA's operations. The "most vital defect," of course, was the association's violation of medical ethics through advertising and solicitation of patients. The committee leveled other accusations at MIHA, as well. First, the maximum annual income that MIHA set for subscribers was chosen arbitrarily, without adequate study. By fixing the maximum annual income at \$1800, MIHA allowed executives and school teachers to enroll in their plans. Non-MIHA doctors suffered as a direct result: those executives and school teachers who ordinarily would have patronized MCMS physicians took their illnesses to MIHA instead, and paid a reduced rate for it.

Second, MIHA failed to achieve its primary objective of successfully competing with the commercial hospital associations. The committee concluded that MIHA actually had "no appreciable effect on the proprietary hospital associations," largely because it

¹⁷⁴ Committee on the Study of Medical Care for Low-Income Persons, "Report to the Council of the Multnomah County Medical Society," October 1935. OHSU Archives, MSS

drew its patients largely from groups which had never before been brought under medical care contracts. Rather than depleting the proprietary associations' patient rolls, MIHA actually further advanced contract medicine: through its reduced rates, MIHA created the impression that medical care could be purchased at a low price, and that the society physicians' usual charges were exorbitant. Of course, quality care could not be purchased at such a low price, and the committee noted the decreased quality and increased morbidity rates among MIHA patients.

Third, despite MCMS's nominal approval of the association, MIHA really operated without sufficient Society control. Not all of the society members participated in the association. Mainly the older, better-established doctors benefited from the patient loads, when young, newer physicians should have received patients from the MIHA rolls. "It seems apparent," the committee wrote, "that any plan changing the method of delivering medical service to any class in the community, affecting, as it must, the entire medical profession, should be under close and immediate supervision by the local medical society." The association's many defects, they reasoned, were "due in considerable part to the absence of such control."¹⁷⁵

The committee struggled to offer a viable alternative to MIHA's plan. They did, however, develop a set of fundamental principles for developing a plan of care for low-wage workers. An ethical plan, they suggested, would be under complete society control. Furthermore, all society members would be permitted and encouraged to join in order to spread the patient loads more equitably, and the plan would operate without solicitation

¹⁷⁵ Ibid., p. 4.

or advertising. The existing proprietary hospital associations, as well as MIHA, clearly violated these principles. The committee thus recommended that MCMS express its disapproval of its members' affiliation with these associations, "to the extent of expulsion from the society, after present outstanding contracts have expired."¹⁷⁶ Writing wishfully, the committee suggested that the hospital associations could return whence they came: the local medical society might approve of contracts in isolated rural districts which would not otherwise receive medical service.

According to *Northwest Medicine*, the Martzloff report divided MCMS members into two camps. On one side were those opposed to any form of contract practice. On the other side stood those who continued to have faith that MIHA could successfully drive the proprietary hospital associations from the market. The council adopted the Martzloff Committee's recommendations, but because a considerable minority of the society physicians dissented, and the issue was referended to the society's December 18, 1935 annual meeting. This meeting, too, failed to resolve the issue. The *Northwest Medicine* editorial staff later attributed the society's decision to further postpone its resolution to the "high heat" of interest in the issue, which could only harm MCMS's general welfare. Thus, arguments over MIHA's status and the medical society's approach to contract medicine continued over the following months.

Shortly after the contentious December 1935 MCMS meeting, the Oregon State Medical Society stepped into the fray. No longer content to simply observe the local society-sponsored medical service plans from afar, OSMS rejected the view that the only

¹⁷⁶ Ibid., p. 9.

way to compete with the proprietary hospital associations was “by employing the very methods of obtaining patronage which ethical physicians have so long condemned.”¹⁷⁷ The alternative was simple. As OSMS President Thomas Griffith had suggested just five years before, the medical societies needed to present a unified front against the hospital associations. At least one local society, OSMS observed, had achieved this unity, “serving notice upon these associations that they will not attend the patients of these organizations who have been obtained by unethical practices.”¹⁷⁸ This would be the first prong of the private market solution: by restricting the supply of medical ‘labor’ available to the hospital associations, the medical societies would squeeze them out of the market.

As Carl Taeusch argued in the 1920s, this first prong would prove difficult to enforce. The medical societies had no formal control over medical behavior: licensing authority belonged to the state, and the holding of a license was in no way dependent upon membership in the state and local medical societies. Nevertheless, OSMS pressed forward in its quest against contract medicine, recommending that every member be supplied with a copy of the “Principles of Medical Ethics,” and advising them that society membership was contingent upon their acceptance of these principles.

The Multnomah Industrial Health Association made efforts to comply with the state and county medical societies’ requests that they abide by the Principles. On

¹⁷⁷ Oregon State Medical Society, “Statement Concerning the Enforcement of the Principles of Medical Ethics,” Adopted by Council, Feb. 17, 1937. OHSU Archive. Accession # 2008-015, Box 1, Folder 7 (Societies, Medical: Oregon State Medical Society, General)

¹⁷⁸ *Ibid.*, p 5.

December 9, 1935, prior to the contentious MCMS meeting on the 18th of that month, MIHA's Board of Directors signaled their intent to cooperate with the society in defining eligibility caps, advertising methods. The board also proposed that the medical society council be given the power to select all candidates for director positions within the association.¹⁷⁹ On July 1, 1936, the association cancelled all salesmen's contracts, pending a ruling from the AMA's Judicial Council defining solicitation.¹⁸⁰ Concerning the critical issue of the schoolteacher contracts, however, MIHA's Board of Trustees approved a renewal of the contract, with the stipulation that no teacher earning above \$1800 annually would be accepted.¹⁸¹

The association's actions were too little, and far too late. The society's state and federal divisions, demonstrating their increased interest in the local experiments in prepaid medicine, dispatched Dr. Morris Fishbein, editor of *The Journal of The American Medical Association*, to Multnomah County. Fishbein delivered a series of lectures over several days in June and July, 1936. In a talk to the Portland Chamber of Commerce titled "Medicine and the Changing Social Order," Fishbein reiterated the common theme of the doctor-patient relationship: the patient had to be "individualized," meaning that no

¹⁷⁹ Dr. Eugene P. Owen, Letter to the Council of the Multnomah County Medical Society, December 9, 1935.

¹⁸⁰ Board of Directors, Multnomah Industrial Health Association, "Letter to Dr. Harold B. Myers," September 25, 1936, OHSU Archive, Accession # 2008-015.

¹⁸¹ Multnomah Industrial Health Association, "Meeting of Board of Directors," Portland, Oregon, March 5, 1936, OHSU Archive, Accession # 2008-015.

commercial or political interests could be permitted to come between him and his doctor.¹⁸²

Fishbein delivered a similar message to MCMS on July 4, 1936. Following his speech, the society voted on two questions: the acceptance of the Martzloff report and the withdrawal of society approval from MIHA.¹⁸³ The affirmative vote supported the council on both instances. Concerning the withdrawal of MCMS's approval of MIHA, the society voted almost 2-to-1 in favor of the council's position, with about 150 MIHA and National Hospital Association-affiliated physicians dissenting. The results of the vote did not immediately affect the 150 dissenters: the society did not move to remove them from the AMA rolls. According to *The Oregonian*, however, "eventual revocation of memberships was seen as a distinct possibility. The medical societies were aware that revoking AMA membership did not affect the practitioner's state license, but predicted that "hospital associations would be seriously crippled because no outside specialist would violate the AMA's ban and accept a call for special work for an association patient."¹⁸⁴

The contemplated membership revocations were soon to follow. In November, 1936, MCMS suspended two physicians affiliated with the National Hospital

¹⁸² "Individualizing Patient Advocated by Fishbein," *The Oregonian*, June 30, 1936, p. 19, col. 2-3.

¹⁸³ "Editorial: The Hospital Association Situation in Portland." *Northwest Medicine*, Vol. 35, No. 8, p. 317.

¹⁸⁴ "Doctors Oppose Group Medicine," *The Oregonian*, July 5, 1935, p. 1, col. 1.

Association.¹⁸⁵ Shortly thereafter, several physicians ‘voluntarily’ resigned their memberships under significant pressure from Society leadership. On the evening of December 4, 1936, Dr. C.G. Sabin submitted his resignation to the Council. In his remarks to the press, Dr. Sabin lambasted the society for undertaking “to destroy institutions recognized and approved by state law through the indirect method of unwarranted attacks upon reputable physicians who care for patients sent to them by these hospital associations...”¹⁸⁶ With this comment, Sabin struck at the heart of the ‘private sector solution.’ Through its attack on individual physicians’ decisions to care for contract patients, the society directly violated the public policy of the State of Oregon. In his official statement to the society, Dr. Sabin declared as much:

The state of Oregon adopted a public policy of encouraging such service to those who could not otherwise enjoy proper care when the legislature of this state enacted a law providing for hospital associations under state regulation... You have now attempted to subvert the declared public policy of the state of Oregon by assailing physicians and surgeons who care for patients sent to them by such hospital associations. Your obvious purpose is to destroy the hospital associations by denying them the services of competent physicians and surgeons. No substitute service is offered by you.¹⁸⁷

Sabin’s statement referred to the regulatory plan adopted by the State of Oregon through the Hospital Association Act of 1917. That law, he suggested, attempted to solve two

¹⁸⁵ “Group Medicine Wins Long Fight,” *The Oregonian*, June 22, 1939, p. 1, col. 1; according to *Northwest Medicine*, the two physicians were actually expelled, and not merely suspended. See: “Oregon Council and Other News Notes,” *Northwest Medicine*, Vol 36, No. 1, p. 33. This detail is relatively unimportant, and neither source seems more accurate than the other.

¹⁸⁶ “Sabin Withdraws from Medic Unit,” *The Oregonian*, December 5, 1936, p. 1, col. 7.

¹⁸⁷ “Sabin Withdraws from Medic Unit,” *The Oregonian*, December 5, 1936, p. 2, col. 4.

issues. First, the state legislature, representing the citizens of the state, lent its support to contract medicine as a legitimate means through which low-income patients could receive medical care. Second, the law represented the political compromise over the hospital association issue. These compromises, once signed into law, deserved the respect of all the competing parties. The medical society's attempt to destroy the hospital associations – even indirectly – violated the unspoken rules of this political process.

Two more resignations followed on the evening of December 5, 1936. Apparently following Dr. Sabin's lead, Drs. JD Leonard and George R. Suckow left the society. Their lawyer, Mr. W. Lair Thompson, echoed Sabin's statements from the night before. He declared, "The medical society has a right to dislike the hospital association idea, and it has a right to fight the growth of the system of 'prepaid medicine,' but it ought to direct its attack against the system and the law that permits the system of medical insurance – not against the doctors who treat the patients."¹⁸⁸ Like Sabin, Thompson argued that the contract medicine issue had to be resolved through public policy, and not by the medical society's unilateral decision to suspend contract doctors.

Two more resignations followed over the next several days. On December 7, 1936, Dr. Tharald Tharaldsen, a former MCMS president, submitted his resignation. A reporter for *The Oregonian* left no doubt that Tharaldsen and the three other doctors left under fire: "The resignations presupposed action by the society's council to oust

¹⁸⁸ "Doctors Resign; Conflict Rises," *The Oregonian*, December 6, 1936, p. 19, col. 3.

them...”¹⁸⁹ A fifth doctor, Dr. Chester Moore, left the society on the evening of December 15th, citing similar differences with MCMS policy.¹⁹⁰

The medical society’s ousters highlighted a key element of the private sector solution, namely that the medical societies would try to restrict the supply of labor to the hospital associations in an attempt to drive them out of business. This tactic was, of course, markedly different from the goal of the 1932 experiments in competing with the proprietary hospital associations by setting up physician-owned ones. The frenzy over the issue in the lay press, however, obscured an important, gradually-evolving, second element of the medical society’s strategy.

The October 1935 Martzloff report first hinted at the second element of the medical society’s strategy in its recommendations to the MCMS council. In addition to expressing disapproval of society members who affiliated themselves with the hospital associations, the Martzloff committee recommended “that the Council institute immediately a study of the present practice of the hospitals in granting special rates to commercial hospital associations below the rates charged the private patients of our members...”¹⁹¹ By ending this practice, the medical society hoped to level the playing field. The hospital associations, of course, were able to secure these rates by virtue of

¹⁸⁹ “Fourth Doctors Resigns Society,” *The Oregonian*, December 8, 1936, p. 1, col. 3.

¹⁹⁰ “Medical Group Loses Another,” *The Oregonian*, December 16, 1936, p. 1, col. 6; “Fifth Doctor Quits Society,” *Portland Oregon News-Telegram*, December 16, 1936, p. 9, col. 1.

¹⁹¹ Committee on the Study of Medical Care for Low-Income Persons, “Report to the Council of the Multnomah County Medical Society,” October 1935, p. 9, OHSU Archives, MSS

their large patient bases. Unable to lock in their own volume discounts, the medical society's first best chance was to eliminate these special rates.

The Martzloff committee also advanced another suggestion which ultimately became one of the most controversial aspects of the medical society's battle against contract medicine. The committee advised that the medical society attempt to convince the hospitals "to make membership in the Multnomah County Medical Society one of the requirements for staff membership."¹⁹² The state medical society's February 17, 1936 *Statement Concerning the Enforcement of the Principles of Medical Ethics* also reflected these sentiments, and refined them into a petition to the House of Delegates of the American Medical Association on April 1, 1936. The petition read, in part,

Resolved, that the Council on Medical Education and Hospitals, before granting approval to hospitals for general internships or residencies in the several specialties, shall first assure themselves that each and every staff member of any hospital under consideration for such approval is conducting his practice in accordance with the Principles of Medical Ethics, and that such hospital is not granting special privileges to any of its staff members in the form of lower rates for patients of such staff members.¹⁹³

According to the OSMS Committee on Medical Education and Hospitals, the block rates that the proprietary hospital associations were able to secure resulted directly from their doctors' "inclusion on the staffs of some hospitals."¹⁹⁴

¹⁹² Ibid.

¹⁹³ "Minutes of the Sixty-Second Annual Meeting of Oregon State Medical Society," *Northwest Medicine*, Vol. 35, No. 12, p. 470.

¹⁹⁴ Ibid., p. 473.

By excluding hospital association-affiliated physicians from hospital staffs, the state medical society would achieve goals. First, they would eliminate the “pernicious” block rates that they despised so much. Second, and perhaps more importantly, they would control the site at which healthcare was delivered. The medical profession was keenly aware that the means by which care was delivered was rapidly changing. According to a 1936 speech by Idaho State Medical Association President J.H. Crampton, reproduced in *Northwest Medicine*, the position of the family physician was declining. At the same time, technological progress introduced “hundreds of sentimental, semimedical workers, not fully trained as physicians” into medical processes. Hospital staffs, heavily made up of these semi-skilled workers, were easily tricked into supporting commercialized and state medicine, which Crampton argued “looks to them like a mecca.” To make matters worse, the physician’s situation was exacerbated by the modern family’s increasing demand for hospitalization.¹⁹⁵ The OSMS petition took a step toward alleviating the physician’s pain: by threatening to restrict the supply of crucial specialists to the hospitals, the medical societies would be able to exercise greater control over the distribution site of modern medical care. The AMA House of Delegates approved the petition, and it became an official AMA policy in mid-1936.¹⁹⁶

As the medical society developed and implemented its new strategy, the conflict between organized medicine and contract doctors reached fever pitch. By mid-December,

¹⁹⁵ J.H. Crampton, “The Spectre of State Medicine,” *Northwest Medicine*, Vol. 35, No. 10, pp. 368-369.

¹⁹⁶ “Minutes of the Sixty-Second Annual Meeting of Oregon State Medical Society,” *Northwest Medicine*, Vol. 35, No. 12, p. 473.

1936, the lay press clearly expected the issue to surface in the upcoming 1937 legislative session. The *Portland Oregon News-Telegram* predicted that the medical societies would sponsor legislation that would effectively “either wreck the associations outright or so tie their hands that they can’t operate.”¹⁹⁷ Failing that, the hospital associations could at least expect the society “to make hospital association doctors the “black sheep” of the medical profession.”¹⁹⁸

Anticipating the upcoming battle, Oregon’s large industries (those with total workforces numbering at least 15,000) commissioned an industry survey concerning contract practice. Oregon Business and Investors, Inc., the group primarily responsible for carrying out the study, declared that it planned to exert its influence against any legislation which would curtail their right to contract for medical aid. “Such curtailment or prohibition would,” they declared, “seriously interfere with the medical care problem for large groups of employes, particularly in small communities where adequate service might not otherwise be available.”¹⁹⁹

On its surface, the hospital association issue became one primarily about how to effectively and efficiently deliver medical care to low income patients. The *Oregon Voter Magazine*, a political publication in which local industries and proprietary hospital

¹⁹⁷ “Professions Will Fight in Legislature,” *Portland Oregon News-Telegram*, December 19, 1936, p. 2, col. 1.

¹⁹⁸ *Ibid.*

¹⁹⁹ “Employers for Contract Aid,” *Portland Oregon News-Telegram*, December 23, 1936, p. 7, col. 6; “Group Medical Care Favored, Says Young,” *The Oregonian*, December 23, 1936, p. 12, col. 4.

associations advertised heavily, defended the business practices the medical society had attacked:

If corporate responsibility is to be barred from contributing to the solution of the problems involved in the cost of medical care for all the people, the trend will fix itself, we fear, towards what doctors fear most-Social Medicine, with its potentialities for evil.²⁰⁰

By threatening to drive out the proprietary hospital associations, the medical society would only hasten the growth of socialized medicine. Under a physician-dominated system, patients resisted the high costs of medical care and delayed treatment until their illnesses went beyond what modern medicine could achieve. The proprietary hospital associations, on the other hand, were accessible due to their low annual rates. Furthermore, the associations actually promoted patient choice. The AMA, of course, had claimed that differences in physician quality were sufficient to promote patient choice. Patients would simply approach the physicians who had reputations for producing the best outcomes. According to *Oregon Voter* magazine, however, the hospital associations actually provided more information to the patient: patients could choose the hospital association with the best public image. Simply put, contract medicine solved many of the problems of modern medical care, and the medical societies had no good reason to interfere with a system that was already working.

²⁰⁰ “Doctors Fear Social Medicine,” *Oregon Voter*, December 5, 1936, Vol. 87, No. 10, p. 282.

The Hospital Associations Fight Back: The 1937 Session of the Oregon State Legislature

The surface-level debate over the best method for delivering medical care obscured another, ultimately more important issue: where, how, and by whom would the contract medicine issue be resolved? When the Oregon state legislature convened on January 11, 1937, the answer to these questions seemed clear: the contract medicine issue would be resolved by the elected representatives of the people through agreed-upon political procedures. Ultimately, however, the session failed to resolve the issue at all. Instead, the medical societies and the leading proprietary hospital association, the National Hospital Association, may have attempted to use the legislative session to gain advantages in the private market.²⁰¹

Contrary to popular expectation, the proprietary hospital associations, and not the medical societies, were the ones to sponsor legislation. The National Hospital Association put its weight behind four bills aimed directly at the medical society's two-pronged strategy. First was a controversial package of three bills, House Bills 281 – 283, amending the regulation of commercial hospital associations. Second was a single bill, H.B. 352, concerning the right of physicians to practice in hospitals. The NHA's motives in introducing the bills were not entirely clear, but the texts of the proposed legislation

²⁰¹ Lest there be any doubt that the activity in the 1937 legislative session was related to the medical society conflicts of late 1936, see February 4, 1937 report in *Portland Oregon News-Telegram*. The paper reported that the legislative battle was “the aftermath of a controversy in Portland that divided the Multnomah Medical society and resulted in the resignation of several doctors.” [“Measures Stir Controversies,” *Portland Oregon News-Telegram*, February 4, 1937, p. 2, col. 5.]

and reports of the committee meetings suggest a strategy with both offensive and defensive components.

The NHA enlisted the help of Representative N. Ray Alber (D-Portland), an attorney with ties to the lumber industry and a prominent member of the Oregon House, to introduce House Bills 281 – 283 on February 4, 1937.²⁰² House Bill 281 primarily dealt with financial regulations. It increased the amount of capital stock required of a new entrant to the prepaid medical services market from \$5,000 to \$10,000 and stipulated that the capital be unimpaired. The bill also increased the surety bond that new associations were required to file from \$10,000 to \$15,000. Additionally, H.B. 281 enhanced the state insurance commissioner's power to regulate hospital associations. The existing code required the associations to file an annual report. The new legislation would allow the commissioner to examine each association's financial condition "at least once a year..., and oftener, if he deems it prudent so to do."²⁰³ To enforce regulations, the bill gave the insurance commissioner the power to revoke an association's right to transact business in the state, subject to review by an administrative board, and appealable to the Oregon circuit and supreme courts.²⁰⁴ Finally, the bill dramatically expanded the scope of the activities which might be regulated. The already-existing code classified hospital association activities as involving "professional, medical or hospital

²⁰² "Who's Who in the House," *Oregon Voter*, Vol. 88, No. 1, January 2, 1937, p. 43; Oregon. House. *House Calendar for the Thirty-Ninth Legislative Assembly*, State Printing Department, 1937.

²⁰³ Oregon. House. *House Bill No. 281*. Thirty-Ninth Legislative Assembly, 1937, p. 5.

²⁰⁴ *Ibid.*, p. 6

services and supplies as accidents or illness sustained [by employees] may require.” The bill proposed to eliminate this text from the code, replacing it with “hospital care, nursing, dental service or any other care and attention contingent upon sickness or injury...”²⁰⁵

This amendment to the original regulations would bring the activities of the rapidly urbanizing hospital associations under the commission’s supervision.

House Bill 282 concerned the right of employers to make contracts with hospital associations to provide medical care for their employees. Unlike H.B. 281, this bill invested the state industrial accident commission (SIAC) with supervisory power over hospital association contracts. The industrial accident commission, however, received far less discretion in canceling contracts than the insurance commissioner did in H.B. 281. House Bill 282 listed several factors which SIAC would have to look for in canceling a contract: “the services being provided [under the contract] are not adequate and proper or that the contracting party is not competent or qualified or has neglected or failed to provide proper services and care of the injured workmen.”²⁰⁶ Of course, SIAC’s power was limited to contracts made between employers and hospital associations. The insurance commission, on the other hand, had the power to regulate all hospital associations doing business in the state of Oregon.

House Bill 283 sanctioned employers’ collection of fees for hospital association contracts, but added in several protections for workers. Section 3 of the bill allowed a worker to opt out by providing written notice to his employer. The section also dealt

²⁰⁵ Ibid., pp. 2-3.

²⁰⁶ Oregon. House. *House Bill No. 282*. Thirty-Ninth Legislative Assembly, 1937, p. 3.

with the mobility problem expressed by the state federation of labor in the 1920s: under H.B. 283, any employee who had paid a fee for any time period and left employment before that time period elapsed would be issued a receipt and would be entitled to the care he had paid for.²⁰⁷ Section 6 imposed certain limits on solicitation, although those limits did nothing to force a modification of NHA's business practices. Finally, sections 8 and 9 enhanced the insurance commissioner's supervisory authority in the same manner as done in H.B. 281.²⁰⁸

The day following the bills' introduction and first reading to the House on February 4, 1937, the measures were referred to the House Committee on Medicine, Pharmacy, and Dentistry.²⁰⁹ Controversy ensued over the next two weeks, and centered mainly on the stock capital and surety bond requirements of H.B. 281, and the increased scope of the insurance commissioner's regulatory authority in both H.B. 281 and H.B. 283.

In a meeting on February 8, 1937, two physician-members of the Committee on Medicine, Pharmacy, and Dentistry charged that Alber's bills constituted an attempt by the NHA to gain a greater market share at the expense of small hospital associations. Dr.

²⁰⁷ Oregon. House. *House Bill No. 283*. Thirty-Ninth Legislative Assembly, 1937, p. 2; See also: "Public Meeting of the Legislative Workmen's Compensation Committee of the State of Oregon," February 19, 1926, Oregon State Archive, Box

²⁰⁸ The bill's author used a basic police power argument to support the insurance commissioner's enhanced supervisory authority: the State has the ability to make laws to promote the safety, health, morals, and general welfare of the citizens under police power.

²⁰⁹ Oregon. House. *House Calendar for the Thirty-Ninth Legislative Assembly*, State Printing Department, 1937, p. 38.

C.D. Hockett (R-Wallowa County) declared, “This is an attempt to create a monopoly.”²¹⁰ Hockett’s counterpart on the committee, Dr. J.F. Hosch (D-Deschutes), said, “They’re saying ‘you little guys get out of the way and we big fellows who are businessmen will run this, not you fellows who know something about medicine.’” Both Hockett and Hosch referred to the proposed \$5000 increase in bond and capital stock requirements. The ‘big fellows,’ they believed, could meet the new requirements easily, but the new regulations would drive smaller associations out of business. Neither Hockett nor Hosch probably wanted to ensure a competitive, healthy market for the proprietary hospital associations, however. Hosch clearly understood the physicians’ obligations to the medical society, stating, “If this bill goes out of this committee on a divided report among the doctors, there’ll be a h--l of a fight in the medical society.”²¹¹ The medical society had already made its stance on proprietary hospital associations clear. Therefore, Hockett and Hosch were most likely concerned about the power NHA might wield if it succeeded in driving smaller hospital associations out of the market. Much of the December 1936 drama inside of MCMS revolved around doctors affiliated with NHA, and the medical society probably desperately wanted to block legislation which would give NHA a leg up in the private market.

The National Hospital Association soon had its turn to defend the legislation. At a committee meeting on the evening of February 10, A.E. Clark, attorney for NHA, denied that H.B. 281 was an attempt to freeze out small companies:

²¹⁰. “Governor Backs Mining Measure,” *The Oregonian*, February 9, 1937, p. 1, col. 5.

²¹¹ Ibid.

I wish to deny the charge that increases are an attempt to freeze out the small hospital companies. The obligations that a hospital association undertakes make it necessary that there be sufficient guarantee that the contract to care for people will be fulfilled.²¹²

Framing his argument in terms of corporate responsibility, Clark argued that the increased surety bond and stock capital requirements were necessary for ensuring that hospital associations would be able to fulfill the promises they made through their contracts. Hosch expressed disagreement with Clark's assessment: why did the bill establish a flat requirement? The discussion which followed suggested that H.B. 281 might have a chance of passing if the committee incorporated a sliding scale between big and small associations, with the capital and bond requirements for the latter set significantly lower.²¹³

The February 10 meeting also brought forward the issue of which agency would supervise the hospital associations. Unsurprisingly, Assistant Insurance Commission Sehorn expressed approval of the bill which would enhance his department's regulatory power. Hospital associations, he declared, were "something that have come to stay and should be put on a dignified, substantial basis."²¹⁴ In other words, the increased regulations would actually benefit the proprietary hospital associations, for it would confer upon them the state of Oregon's mark of approval. As the driving force behind

²¹² "Clark Appears for Hospitals at Legislature," *Salem Capital Journal*, February 11, 1937, p. 14, col. 1.

²¹³ Ibid.; "Backers Feature Hospital Hearing," *The Oregonian*, February 11, 1937, p. 11, col. 6.

²¹⁴ "Backers Feature Hospital Hearing."

the bills, and as a company with close ties to the insurance department, NHA almost definitely agreed with these sentiments.²¹⁵

The Oregon State Federation of Labor (OrSFL) occupied a middle position at the February 10 meeting, neither completely opposing nor completely supporting the bills. For the federation, the issue of agency power was of paramount importance. Attorney B.H. Green attended the meeting as the federation's representative. The insurance commission, he argued, should not administer the act. Instead, the hospital associations should be supervised by SIAC.²¹⁶ Like the NHA position of enhancing the insurance department's regulatory power, Green's argument was unsurprising. The federation had cultivated a close relationship with the industrial accident commission: one member of the commission was drawn from labor's ranks, and the OrSFL undoubtedly had close

²¹⁵ The proprietary hospital associations' close connections with the insurance department dated back to the formulation of the original hospital association regulations passed in 1917. The Insurance Commissioner's correspondence files demonstrate that the commissioner consulted with NHA in creating legislative proposals. A November 2, 1916 letter to the commissioner from C.C. Bechtold, General Manager of the National Hospital Association, advises, "I am inclosing you herewith a proposed Section to the Insurance Code relative to Hospiatl [sic] Association as per our conversation the early part of this week." [C.C. Bechtold, Letter to the Insurance Commissioner, November 2, 1916, Oregon State Archives] The Insurance Commissioner replied several days later, writing, "This is to advise that I will try and get the general committee to permit me to make this part of the code, although several members objected to this and at a general meeting recently the hospital association section was eliminated. However, if it does not become a part of the code I personally will recommend it to the Legislature and request that it become a part of the insurance code." [Insurance Commissioner, Letter to C.C. Bechtold, November 6, 1916, Oregon State Archives]. Although the exact provisions in question are missing from the records, the short exchange between Bechtold and the Insurance Commissioner suggests that NHA probably supported enhanced regulatory power for the insurance department because it could influence agency decision-making.

²¹⁶ "Clark Appears for Hospitals at Legislature."

contacts on the commission staff. Even if it does not serve as conclusive proof, the exchange between Green, Sehorn, and Clark suggests that H.B. 281 reflected motivation on the part of the NHA to place decision-making on some aspects of contract medicine in an agency favorable to the proprietary hospital associations.

On February 16, opponents of the Alber bills had their chance to address the House Committee. Dr. Richard Adams, a representative of MCMS, attacked the legislation vigorously. Repeating earlier criticism advanced by the medical profession's members on the committee, Adams argued that the larger bond and capital stock outlays required by the bill would push the contract medicine industry toward monopoly. "These bills," he declared, "will further entrench corporate practice of medicine."²¹⁷ Adams framed his argument in terms of patient rights, stating that the medical society's "attack on this bills is entirely in the patients' behalf. The laborer pays too much for too little."²¹⁸ Curiously, however, labor's main objection to the bills was that they enhanced the insurance commission's regulatory power instead of SIAC's. Thus, the medical societies were mostly likely more concerned about the impact an even more-powerful NHA would have on organized medicine than the effect the bills would have on patient care.

The committee met for a final time on the morning of February 17. After reading a "do not pass" report to the clerk, the three Alber bills were pulled out of the committee

²¹⁷ "Opponents of Hospital Bills Have Innings," *Salem Capital Journal*, February 17, 1937, p. 12, col. 4.

²¹⁸ *Ibid.*

by surprise and met decisive defeat on the House floor. Alber desperately tried to revive his bills through a move to table and amend them, but the House shouted his motion down by a loud “aye” vote.²¹⁹

Ultimately, H.B.s 281-283 probably failed for two reasons. First, although the bills contained a number of provisions amenable to labor, OrSFL was unwilling to trade their influence in regulatory decision-making through SIAC for the employee protections outlined in section 3 of H.B. 283. Commenting on the events of February 17, pro-labor Representative Phil Brady pointed out that labor deserved a say in hospital association rates, and that this power should not be turned over completely to the insurance commission. “[L]abor,” he stated, “is in accord with the state industrial accident commission.”²²⁰ Second, the medical societies effectively controlled a sufficient number of seats on the House Committee on Medicine, Pharmacy, and Dentistry to block legislation that they opposed. The editors of *Northwest Medicine* praised Dr. Hockett’s service on the committee, and wrote favorably of the profession’s service in the legislature, remarking that the doctors “should be remembered as exerting effective influence in the passing of favorable legislation and blocking objectionable bills.”²²¹

The medical profession may have participated in the legislative process, but its actions did not suggest that it would seek a public resolution of the contract medicine

²¹⁹ “Kill Three Bills for Hospital Association,” *Salem Capital Journal*, February 17, 1937, p. 1, col. 3.

²²⁰ *Ibid.*

²²¹ “Legislative Medical Acts,” *Northwest Medicine*, April 1937, Vol. 36, No. 4, pp. 136-137.

issue. The defeat of H.B.s 281-283 probably turned back an offensive action by the NHA. Although the evidence as to motivation is inconclusive, the three Alber bills certainly would have legitimated the large proprietary hospital associations and given them an economic advantage over the medical societies. The fourth and final NHA proposal, however, was largely a defensive reaction to medical society actions, and the physicians' response to H.B. 352 suggests that the medical societies sought to continue to resolve the contract medicine issue privately.

House Bill 352, introduced by the Committee on Medicine, Pharmacy, and Dentistry on February 8, 1937, made it unlawful "to deny the use of the facilities of any property devoted to hospital purposes... to any qualified and reputable physician or surgeon, authorized to practice in this state, solely on the ground that he is not a member of any local, state, or national medical society or association..."²²² The medical societies, of course, had no formal control over licensing, and the bill's preamble was quick to point the state of Oregon's authority on these matters. The bill targeted the medical societies' previous attempts to control the sites at which healthcare was delivered, and gave their victims legal remedies against them (action to recover damages, enjoinder). The Oregon State Medical Society was keenly aware that H.B. 352 was a defensive move on the part of the NHA:

This association also sponsored House Bill 352, to prevent the hospitals from exercising control over the ethical standards of their staffs. This bill was designed to render ineffective the resolution relating to the approval of hospitals for

²²² Oregon. House. *House Bill No. 352*. Thirty-Ninth Legislative Assembly, 1937, p. 1.

interneships [sic] and residencies which was adopted at the 1936 Session of the American Medical Association.²²³

The OSMS's strategy, of course, was to restrict hospital access only to medical society-affiliated physicians. Even in its early phases, the strategy clearly proved concerning to the NHA, and thus H.B. 352 constituted a defensive move by the proprietary hospital associations.

Once again, the medical society's legislative strategy worked to defeat the measure. The bill was originally referred to the Committee on Legislation and Rules, which appears to have been more favorable to NHA interests, for it rapidly reported it back with the recommendation that it be considered on February 8. The next day, H.B. 352 was referred to the Committee on Medicine, Pharmacy and Dentistry, where the physician members of the committee probably effectively killed it.²²⁴ Thus, the hospital association issue continued to be decided by the medical societies' actions in the private market. Contract medicine would not be dealt with through agreed-upon political processes and rules.

Conclusion

By the mid-1930s, OSMS had successfully removed the hospital association issue from the public sphere. In doing so, it substituted its own private code of ethics for

²²³ "Minutes of the Sixty-Third Annual Meeting of the Oregon State Medical Society," *Northwest Medicine*, Vol. 36, No. 12, p. 440.

²²⁴ Oregon. House. *House Calendar for the Thirty-Ninth Legislative Assembly*, State Printing Department, 1937, p. 45.

publicly voted-upon regulations. Two factors contributed to OSMS's success at this. First, the medical societies themselves developed internal cohesion. Lack of agreement over the permissibility of contract medicine had stymied legislative efforts against the hospital associations in the 1920s. By threatening to expel hospital association-affiliated physicians in 1935, the medical societies gained the level of internal control needed to take a unified stance on the issue. Second, the very same procedural rules that protected the hospital associations against organized labor and medicine in the 1920s finally worked in favor of the physicians. The physicians obtained enough committee seats to effectively block the hospital associations' attempts to use public regulation to defend themselves. As the medical societies substituted their own rules through processes available only to their members, and not the general public, the hospital associations found it far harder to erect additional regulatory defenses than it previously was to block undesirable legislation.

Having successfully defended its power to regulate the prepaid medical services market through its private code of ethics, OSMS would continue and expand its private sector strategy through 1949. Whether that period reflected a continuous policy on the part of the medical societies, however, would eventually become the subject of debate with serious implications for public policy concerning the regulation of prepaid medical services.

CHAPTER IV

THE OREGON STATE MEDICAL SOCIETY BEFORE THE SUPREME COURT

Private codes of ethics are not a substitute for the law; and private regulation of prepaid medical care business is not a substitute for the competitive principles of the Sherman Act.

– United States Department of Justice, 1949

This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession.

– United States Supreme Court, 1952

When the Oregon State Medical Society celebrated its victory at the 1937 legislative session, its private sector strategy against the hospital associations was really only in its infancy. The next twelve years saw dramatic developments, which ultimately brought the issue once again into the public sphere. In 1952, the United States Supreme Court decided the case of *United States v. Oregon State Medical Society*, and in doing so, validated the medical society's substitution of its private code of ethics for public regulatory statutes.

The Medical Service Bureau Solution

The medical societies may have won their battles in the 1937 legislature, but they had done nothing to deflect the criticisms leveled at them by *Oregon Voter* magazine, Dr. C.G. Sabin, and countless other critics: they offered no viable alternative. Absent some solution for the care of low-wage earners, the threat of social medicine still loomed large. Thus, on July 20, 1937, OSMS took its first steps toward developing a program to replace

contract medicine. Hoping to have “something constructive to offer, if possible, at the next session of the legislature,” the Council of the OSMS voted to establish a committee to “study the problems of contract practice in all local communities” and to develop guidelines for the state and local societies for dealing with those problems.²²⁵

On April 2, 1938, the OSMS Committee on Medical Economics submitted two reports to the OSMS council, arguing that prepaid low-income medical care was “here to stay”; that the society should develop its own plans to replace those of the hospital associations, both lay and physician-owned; and that OSMS should establish a group hospitalization plan that would eventually include both workers and their families. After discussing the reports, the council asked the committee to develop a statewide plan of low-income medical care.²²⁶

After several months’ work, the Committee on Medical Economics presented its plan to the OSMS Council and Executive Committee on June 25. The Council shied away from Committee’s proposal for a statewide corporation to engage in contract practice and directly compete with the proprietary hospital associations, however. In place of the Committee’s proposal, the Council substituted its own “Statement of Policy and Program for the Medical Care of Low-Wage Industrial Groups.” The Council

²²⁵ “Elimination of Contract Practice,” *Northwest Medicine*, August, 1937, Vol. 36, No. 8, p. 288. Regarding the medical societies’ awareness of the threat of social medicine, see *Northwest Medicine* editorial for January, 1938: “The threat of state medicine which looms on the horizon with varying intensity is a source of agitation which cannot be suppressed.” [“The New Year Outlook,” *Northwest Medicine*, January, 1938, Vol. 37, No. 1, p. 24.]

²²⁶ “Proceedings of April Council Meeting,” *Northwest Medicine*, May, 1938, Vol. 37, No. 5, p. 157.

approved the statement on August 6, and OSMS House of Delegates took up this alternative proposal on August 24 at the state society's annual meeting.

The "Statement of Policy" took a deliberate and cautious approach.²²⁷ Unlike the Committee's recommendation for a completely centralized group hospitalization plan, the Council's August 25 statement reserved a certain degree of local autonomy for the county medical societies. Instead of a statewide group hospitalization plan, each local medical society would "be requested to indicate whether the problem of contract practice and the medical care of the low-wage industrial groups in its local community is such as to make desirable the organization of a special plan to provide medical care to such groups."²²⁸ Any local plans which were developed would remain completely within the county medical society's jurisdictional boundaries, absent express permission by OSMS to expand geographically.²²⁹

The Council justified its preservation of local autonomy along three general lines. First, in reference to the ongoing battles surrounding socialized medicine, it stated that a statewide plan "could be readily seized upon by selfish politicians as the foundation for a

²²⁷ The report's preamble reads, "The medical profession of Oregon has reached a crucial point. The decisions we make during this and the ensuing few years will determine permanently the future of medical practice in this state. For this reason, it is vital that we proceed deliberately and cautiously." ["Minutes of the Sixty-Fourth Annual Meeting of Oregon State Medical Society," *Northwest Medicine*, Vol. 37, No. 11, p. 367.]

²²⁸ "Care of Low-Wage Earners by Oregon State Medical Society," *Northwest Medicine*, Vol. 37, No. 9, p. 302.

²²⁹ The official report does not indicate the contextual reasons for this restriction, but the reader should recall that the Multnomah Industrial Health Association expanded into Washington County not more than two years after its initial establishment.

system of state-controlled medicine.”²³⁰ Second, the transfer of state-level medical society authority to an outside group responsible for administering the plan carried with it certain risks. Most importantly, the society would lose direct control over the enforcement of the principles of medical ethics. Furthermore, such a plan had the potential to create dissension within OSMS ranks. The state medical society clearly hoped to avoid a repeat of the 1936 MCMS debacle. Third, OSMS would lose its “position... as an independent, censorial mechanism” if it approved a statewide plan.²³¹ This third and final objection served as the basis for the plan that the committee did propose.²³²

The plan followed a structure similar to the delegation of power by a state legislature to local governments.²³³ The state medical society would retain censorial

²³⁰ “Minutes of the Sixty-Fourth Annual Meeting of Oregon State Medical Society,” p. 368. For general context, see: Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), pp. 280-289.

²³¹ Ibid.

²³² One additional reason for the medical society’s caution may have been then-active antitrust proceedings against the American Medical Association. At an April 2, 1938 meeting, the OSMS Council discussed United States House Resolution 452, which called for an investigation of the AMA’s attempt to interfere with Group Health Association, Inc., a DC-based hospital association-like body. [“State Departments: Oregon,” *Northwest Medicine*, May 1938, Vol. 37, No. 5, p. 156]. That case eventually came before the US Supreme Court as *American Medical Assn. v. United States*. Among other things, the court held that the AMA was properly indicted and convicted of conspiring to violate Section 3 of the Sherman Act. [*American Medical Assn. v. United States*, 317, U.S. 519 (1943)]

²³³ American legal theory holds that local governments are the creatures of the states. The states are the fundamental units in American democracy, and both the federal and local governments derive their powers from the states. Any power that the local governments hold is delegated to them by the states. When delegating legislative power,

control, disciplining those groups which violated the principles of medical ethics, and it would also develop ethical standards and policies for the county medical societies to follow in setting up their own group plans. Key to developing these standards would be a new state Bureau of Medical Economics, which would be responsible for preparing standard contracts, developing uniform accounting practices, drafting a uniform schedule of rates, and guiding the local organization on the maximum income levels for subscribers.

Following some late-night revisions, none of which affected the Council's recommendations as outlined here, the House of Delegates adopted the plan on a vote described as "unanimous, except that N.L. Tartar of Corvallis... voted in the negative..."²³⁴ Surveying the society's work OSMS President Charles T. Sweeney declared that the plan was the step which would do away with the worst features of contract practice. Now at the end of the decade, however, Sweeney cautioned that the medical societies faced the same situation they had at the beginning:

As long as we have a law on the statute books of the State of Oregon legalizing hospital associations, and no matter by whom owned or how controlled, if they do not break any laws, we will have, perhaps, that unpleasant, if I may say it, competitor to contend with, but we should surely be able now to sell the laborers and even the low-wage earners something better, something cleaner and

whether to a "fourth branch" agency or to a local government, the legislature must set forth basic standards for the exercise of that power. The situation within OSMS with regard to county medical plans was completely analogous. See: Osborne Reynolds, *Local Government Law* (New York: West, 2009).

²³⁴ Ibid., p. 370.

something that will retain that age old tradition of free choice of physician and preserve that time-honored relation between physician and patient.²³⁵

The medical society may have prevented further entrenchment of the hospital associations through their activities in the 1937 legislative session. Their failure to block the 1917 Hospital Association Act through either inattention or inability, however, meant that they would have to compete with the hospital associations in the private market.

In practice, the local plans followed the medical service bureau model developed in Washington state some years before. These medical service bureaus were essentially medical society-owned hospital associations, much like the Multnomah Industrial Health Association was intended to be. In fact, MIHA was soon granted re-approval by MCMS: in April 1937, the MCMS Board of Censors called a meeting to investigate the complaints against MIHA, and found that the latter had both given up solicitation after July 1, 1936 and had corrected the income cap problem that the Marztloff report had objected to. To gain yet more support for society re-approval, MIHA called attention to the anti-hospital association provisions of its bylaws, which forbid its members from affiliating with commercial hospital associations. In October 1938, MCMS granted MIHA – by then renamed the “Oregon Medical Service Bureau” – its approval as the sole approved organization to provide medical care to low-wage industrial workers. In 1939,

²³⁵ Charles Sweeney, “New Plans for Medical Practice,” *Northwest Medicine*, November, 1938, Vol. 37, No. 11, p. 348.

the association underwent a final name change to become the Multnomah Medical Service Bureau (MMSB), and won final MCMS approval.²³⁶

Not long after MIHA's rebirth as MMSB, the medical service bureau solution began to exhibit some cracks. First, the county bureaus started to present territorial disputes to the OSMS Council. For example, in 1940, the Benton County Medical Society complained that MMSB was operating within the Benton society's jurisdiction. A similar complaint cropped up in Linn County the next year, once again the supposed fault of MMSB. Second, OSMS discovered that demands for prepaid medical service did not fit neatly within county borders. In February 1940, the OSMS Council considered a request by the Oregon State Police to allow the Physicians and Surgeons Hospital Association of Salem to serve its employees throughout the state. The Council approved this petition.²³⁷ Pressure was mounting for the establishment of a statewide prepaid medical care system.

Centralization and Competition, 1941-1949

The solution to the overlapping jurisdiction problem came in 1941, with the founding of the Oregon Physicians' Service (OPS). That year, the OSMS Council

²³⁶ In the United States District Court, District of Oregon, Civil Action No. 4255. *United States v. Oregon State Medical Society*. Trial Brief for the Plaintiff, pp. 106-108 (University of Oregon Special Collections Library)

²³⁷ *Ibid.*, pp. 248-251.

adopted a resolution to incorporate OPS, and donated \$6000 in funds to start the plan.²³⁸

At least two factors contributed to this development. First, of course, was the medical society's discovery that demands for medical services did not fit neatly within county borders. Second, the production demands of World War II catalyzed already-existing trends toward more widespread health coverage. Around 1943, Dr. Orlen Johnson of the AMA's Council on Industrial Health remarked, "We recognize that there has been changing concept of industrial health... and we are actively promoting a program which is positive in character, to bring about an improved medical service in industry under the leadership of the medical profession." The OSMS Service Bulletin recounted Johnson's speech, reporting that he attributed the rapid change to the "the sudden development of war industries [which] precipitated these problems far earlier than would otherwise have happened."²³⁹

OPS soon came to replace the medical service bureau model, although not entirely. The official OSMS policy regarding OPS retained county medical society control over prepaid medical service plans within county lines. Only with the county medical society's consent could OPS extend its operations. Such consent was not

²³⁸ In the United States District Court, District of Oregon, Civil Action No. 4255. *United States v. Oregon State Medical Society*. Trial Brief for the Plaintiff, pp. 30-34.

²³⁹ "Oregon is Changing," *OSMS Service Bulletin*, Nov. 1943, Oregon Health and Science University Archives and Special Collections, Oregon State Medical Society Records, Box 4, Folder 20: Prepaid Medicine (Including Oregon Physicians' Service). See also: Carolyn M. Buan and Caroline P. Stoel, *The First Duty: A History of the U.S. District Court for Oregon*, (Portland: U.S. District Court of Oregon Historical Society, 1993) pp. 193-194. Buan and Stoel argued that changes brought about by WWII were largely responsible for the development of OPS.

impossible to obtain. In its first annual report, OPS declared that mergers with the Southern Oregon Medical Society of Medford and the Physicians and Surgeons Hospital Association of Salem were largely completed by the end of 1943.²⁴⁰ The merger between OPS and the Multnomah Medical Service Bureau followed the next June, and the latter was officially dissolved on June 26, 1944. By November 1944, OPS operated in all but six counties, and employed 692 civilian and 191 military physicians on its open panel.²⁴¹ At the height of its operations in December 1944, 90,000 workers subscribed to the service, only to drop to approximately 76,000 by October 1945, a reduction which OPS obviously anticipated with the de-escalation of the war.²⁴²

Had OSMS merely given its approval to, and funded OPS, the commercial hospital associations would have had no legal recourse against the medical society. Unhindered competition in the medical services market, however, was not enough for the medical society. The medical society's strategy from 1936 had already proved its effectiveness. For example, as Charles Pumphrey would later testify in Federal District Court, the Pumphrey Company, a commercial hospital association, went out of business

²⁴⁰ "Oregon Physicians' Service: Summary of Its First Annual Report and Outline of Operation," *OSMS Service Bulletin*, Nov. 1943, p. 7, OHSU Archives and Special Collections, Oregon State Medical Society Records, Box 4, Folder 20.

²⁴¹ "Oregon Physicians' Service," *OSMS Service Bulletin*, Nov. 1944, OHSU Archives and Special collections, Oregon State Medical Society Records, Box 4, Folder 20.

²⁴² "Oregon Physicians' Service," *OSMS Service Bulletin*, Vol. 3, No. 4, Nov. 1945, p. 2, OHSU Archives and Special Collections, Oregon State Medical Society Records, Box 4, Folder 20.

in 1940 after it could not find doctors who would accept its tickets.²⁴³ New plans not sponsored by the medical society soon arose to challenge OPS's position, however. One such plan was Northern Permanente, the predecessor to the modern-day Kaiser Permanente system. In May 1942, Edgar Kaiser, son of Kaiser shipyard owner Henry Kaiser, organized the Northern Permanente Foundation in Vancouver, Washington. Permanente began operation in September of that year with a 70-bed hospital and clinic next to the shipyards. By August 1943, the operation had grown to 330 beds.²⁴⁴

The initial OPS reaction to the Permanente Foundation's founding does not appear to have been overwhelmingly negative. The Service's presence in the Oregon Kaiser shipyards had always been limited: the original OPS contract with Kaiser covered medical service only (Blue Cross took responsibility for hospitalization).²⁴⁵ In March 1944, OPS transferred direct control of its first aid stations to Kaiser yard officials, and, at least according to its own internal correspondence, realized substantial reductions in

²⁴³ "Medicine Trial Testimony Is Highlighted," *Eugene Register Guard*, Oct. 25, 1945, p. 15, col. 3. Online. Accessed 05/07/10. <http://news.google.com>. Concerning "taking" tickets, the hospital associations eventually moved to a situation in which they basically acted as insurers. Their clients presented tickets to approved physicians, who would fill in the relevant details concerning treatments and submit to the hospital association for payment.

²⁴⁴ "Northern Permanente Foundation," OHSU Archives and Special Collections, Oregon State Medical Society Records, Box 8, Folder 14, News: Oregon Physicians' Service.

²⁴⁵ "Oregon Physicians' Service: Summary of Its First Annual Report and Outline of Operation," *OSMS Service Bulletin*, Nov. 1943

first aid and administrative expenses.²⁴⁶ The Permanente Foundation's September 1944 expansion to offer off-the-job sickness and injury coverage and prepaid care for employees' families also failed to provoke a negative reaction from the medical society. In fact, the plan was formulated with the guidance and blessing of the Clark County Medical Society, and received approval from the Washington State Medical Society and the AMA. Neither OSMS nor OPS appear to have written negatively of the plan in their internal documents.²⁴⁷

According to the US Attorney General's later investigation of the situation, OSMS and OPS began to strike out against the Permanente Foundation after the conclusion of the war. At that time, Permanente expanded its plan beyond the Kaiser shipyards and Clark County to build a clinic in Portland and a sales office in Vancouver, and to add non-employee subscribers in both Oregon and Washington. In 1946, OSMS "issued a blast against Permanente" and encouraged physicians to practice as members of MCMS and OPS. The next year, OPS allegedly attempted to influence SIAC not to allow contracts with Permanente. By 1947, OSMS had revived its old policy of threatening to expel members who cooperated with rival medical service plans. The Attorney General's office reported that OSMS refused to admit three Permanente doctors who applied for membership in 1948 and 1949 after clearly stating such a policy. Other doctors, the

²⁴⁶ "Summary of Second Annual Report of Oregon Physicians' Service," (Not dated. Estimated ~late 1944.) OHSU Archives and Special Collections, Oregon State Medical Society Records, Box 8, Folder 14.

²⁴⁷ [Untitled], OHSU Archives and Special Collections, Oregon State Medical Society Records, Box 8, Folder 14.

office alleged, refused to deal with non-society hospital associations after being the subjects of an OSMS propaganda campaign.²⁴⁸

Even prior to the end of war, OSMS appears to have also revived its strategy of controlling the site at which medical care was delivered. The National Hospital Association's records include reports on two 1944 meetings between OPS and MCMS officials and the Portland Council of Hospitals. The report declares that at the first of these meetings, on January 31, OPS representative Dr. Gordon B. Leitch "proposed to the hospitals that they refuse to accept patients sent to them by the casualty insurance companies or any of the hospital associations except the Oregon Physicians Service or other doctor owned associations." The NHA report further alleged that MCMS threatened to refuse to send patients to those hospitals which failed to enter the plan, and that those "present were especially cautioned to keep the meeting secret." When the group reconvened on February 3, the physicians failed to bring the hospitals on board with its plans. The majority of the hospitals' representatives opposed it, and those who approved "stated that they would join in the plan provided it was accepted by all other hospitals of the council." Although the plan appears to have been unsuccessful, the intent was crystal-clear: according to the NHA report, the physicians declared that under the plan, "the old established hospital associations could... be eliminated and the field left open for those associations which the doctors own and control." Once again, the medical

²⁴⁸ In the United States District Court, District of Oregon, Civil Action No. 4255. *United States v. Oregon State Medical Society*. Trial Brief for the Plaintiff, pp. 140, 154-158.

society's private sector solution to the hospital association issue was in full swing, (supposedly) secret meetings and all.²⁴⁹

At the Federal District Court for Oregon

The hospital association situation came to a head on October 18, 1949, when the United States Department of Justice brought suit against the OSMS on behalf of the hospital associations. On October 18, Federal District Judge Claude McColloch heard the first day of testimony in the case of *United States v. Oregon State Medical Society*. The DOJ charged that OSMS, OPS, the county medical societies, and a number of individual physicians within those organizations had conspired to restrain trade and attempted monopoly “on a broad scale” in contravention of sections 1 and 2 of the Sherman Antitrust Act, and “to the detriment of the public.”²⁵⁰

Congress passed the Sherman Act in 1890. According to Louis Galambos and Joseph Pratt, the act originally aimed to restore free markets without increasing the size of the government by striking at concentrated power through the already-established judiciary instead of developing new administrative structures.²⁵¹ Section 1 of the act declared “[e]very contract, combination in the form of trust or otherwise, or conspiracy,

²⁴⁹ Report on meetings of representatives of the Multnomah County Medical Society and the Oregon Physicians Service with Portland Council of Hospitals held on January 31st and February 3rd, 1944,” Farwest American Assurance Records, Oregon Historical Society, Mss 2863, Box 6 of 8, Vol. 16, 1949-1963

²⁵⁰ *United States v. Oregon State Medical Society*, Civil Action No. 4255, Brief for the Government, Filed 10/10/49.

²⁵¹ Louis Galambos and Joseph Pratt, *The Rise of the Corporate Commonwealth*, p. 57.

in restraint of trade or commerce among the several States” to be illegal. The key to this provision was that it limited antitrust actions to those attempts to restraint trade in interstate markets. Section 2 prohibited monopolization and attempts at monopoly by individuals, and also attempts at monopoly through combination and conspiracy.²⁵²

The government, represented in court by Special Assistant to the Attorney General Philip Marcus, advanced three points against the defendants’ activities. First, Marcus argued that medical society’s motives in attempting to interfere with the prepaid medical services market were immaterial. “[T]he Sherman Act,” he wrote, “prohibits them from combining to enforce, through restraints and monopoly, their ideas of right and wrong against others who differ with them. Private codes of ethics are not a substitute for the law.”²⁵³ Whether or not the medical societies acted benevolently, the Sherman Act clearly forbade their conduct. Thus, the case fell within the meaning of the act. Second, Marcus argued that the Sherman Act applied to the case, because the physicians interfered with interstate commerce. Although many of the commercial hospital associations operated only within Oregon’s borders, drugs and medical supplies flowed over those borders, and many policyholders hailed from outside of the state.

Marcus’ third and final argument was the most contentious, and ultimately the point on which the case turned. Having attempted to establish that the Sherman Act applied to the case, Marcus now offered evidence that the defendants had indeed

²⁵² *United States v. Oregon State Med. Soc’y*, 343 U.S. 326 (1952), footnote 3.

²⁵³ *United States v. Oregon State Medical Society*, Civil Action No. 4255, Brief for the Government, Filed 10/10/49, p. 9.

attempted to conspire to restrain trade and to monopolize the prepaid medical services market. The key to the argument was Marcus' periodization of the events. He grouped the medical societies activities into four periods. From 1930 to 1936, the medical societies attempted to expel the proprietary hospital associations from the market through the establishment of MIHA. In 1936, the strategy took a new turn, as the medical societies tried to take control over the supply of medical labor by threatening to expel those physicians who cooperated with the hospital associations. From 1936 through 1941, the medical societies continued to use the threat of expulsion to keep physicians in line, and attempted to monopolize the prepaid medical services market through their county-level medical services bureau. Finally, from 1941 to the date of the case, the physicians continued this practice through the establishment of OPS.²⁵⁴ Because the government sought an injunction against the medical societies, Marcus had to tie the 1936-1941 and 1941-present periods together. The most obvious evidence of conspiracy came from the former period. Had the activity ceased to occur after 1941, the court would have nothing to issue an injunction against. Thus, the entire case depended on the integrity of this connection.²⁵⁵

²⁵⁴ In the United States District Court, District of Oregon, Civil Action No. 4255. *United States v. Oregon State Medical Society*. Trial Brief for the Plaintiff, pp. 47-140.

²⁵⁵ OSMS's arguments are conspicuously absent from this narrative. Only the briefs for the United States were available in the University of Oregon Special Collections Library. Both the opinions of Judge McColloch and the United States Supreme Court probably reflect OSMS's arguments. For limited information on the OSMS side of the proceedings, see: "Organized Medicine Is on Trial," *Tri City Herald*, Oct. 10, 1949, p. 111, col. 1, Online, accessed 05/07/10, <http://news.google.com>. This article reveals that Attorney Nicholas Jaureguy argued for OSMS.

Judge McColloch immediately severed that very connection when he delivered his opinion on September 28, 1950. The events were best grouped into two periods, he argued: the time prior to the establishment of OPS in 1941, and the time following it. Regarding the former, he wrote, “This period is ancient history. It has no legal or causal connection with the period 1941 to date...”²⁵⁶ Having settled that issue, McColloch moved on to the only remaining question: whether the physicians violated anti-trust laws through the formation of OPS. On this point, he stated, “I really doubt that the Government believes the operations of Oregon Physicians’ Service are monopolistic.”²⁵⁷ OPS’s major competitors, McColloch pointed out, were “tremendously profitable,” whereas OPS itself faced “weaknesses inherent in cooperative enterprise.”²⁵⁸

McColloch attempted to further reinforce his holding, however, by declaring that the physicians’ pre-1941 activities did not violate the Sherman Act. He wrote, “[D]efendant doctors and medical societies have not restrained or sought to restrain the use of hospital facilities by others, except in cases of lawful and legitimate professional discipline of individual doctors for unprofessional conduct detrimental to their patients, to the hospitals, and to the public generally.”²⁵⁹ McColloch’s analysis of the pre-1941 period was, of course, completely unnecessary given his conclusion that the

²⁵⁶ United States District Court for Oregon. *United States v. Oregon State Medical Society*, Civil Action No. 4255, Opinion, Findings and Notes, p. 2.

²⁵⁷ *Ibid.*, pp. 2-3.

²⁵⁸ *Ibid.*, p. 3.

²⁵⁹ *Ibid.*, p. 4.

establishment of OPS in 1941 did not constitute a continuation of previous monopolistic practices, as the government had argued. Here, he sought to introduce a new rule into the law. For the physicians' conduct to be "lawful and legitimate," McColloch had to treat medicine as distinct from ordinary business and trade. He did just this, writing, "I will make a finding and/or conclusion that the practice of medicine is not a trade within the meaning of the Sherman Law."²⁶⁰ The case hardly turned on this issue, but on appeal, the Supreme Court of the United States would consider and approve McColloch's holding. In doing so, it would validate the physicians' private sector solution of the past twenty years.

The Supreme Court Decides

Following its loss at the District Court level, the government appealed to the United States Supreme Court. The Supreme Court heard oral arguments on the fourth and seventh of January, 1952. Several months later, on April 28, 1952, Justice Robert Houghwout Jackson delivered the opinion of the court.

The government's argument had four parts. First, the brief argued that Judge McColloch's factual findings were erroneous. The appellees had in fact conspired to restrain trade and monopolize the prepaid medical care business. The Supreme Court rebuffed the government along civil procedure lines: Jackson wrote, "The direct appeal procedure does not give us the benefit of review by a Court of Appeals of findings of

²⁶⁰ Ibid.

fact.”²⁶¹ Second, the government attempted to show that OPS was engaged in “trade” or “commerce” under the meaning of the Sherman Act. The court made no ruling on this point, but it did rule against the government’s third argument, that interstate commerce was implicated. The court agreed with Judge McColloch’s findings on this matter, but also refused to try that question again based on prior precedent (*United States v. Yellow Cab Co.*).²⁶²

Once again, the fatal blow was struck at the supposedly weak tie the government drew between the pre- and post-1941 periods. Refusing the review the District Court’s interpretation of the evidence, the Supreme Court accepted McColloch’s finding that the appellees were not engaged in conspiracy to monopoly or restraint of trade after 1941. The government asked for an injunction against OPS, OSMS, and the county societies, and the court held that such a request was impossible to grant. The activity had ceased long before, and therefore the injunction was impossible.

The government had already reversed its fourth argument at Federal District Court. At the Supreme Court, the government tried once again to advance its argument that the medical profession could not justify the restraints it imposed on the medical services market as “reasonable on the ground that they were imposed in an effort to

²⁶¹ *United States v. Oregon State Medical Society*, 343 U.S. 326 (1952), p. 330. Note that the case reached the Supreme Court on direct appeal from the U.S. District Court for Oregon. No Court of Appeals was actually involved in the case.

²⁶² *Ibid.*, p. 332.

maintain asserted professional standards of medical ethics or otherwise.”²⁶³ The government’s argument had two parts. First, it attacked the District Court’s finding that OSMS’s unwillingness to cooperate with the commercial prepaid medical organizations in certain practices was not a conspiracy to restrain or monopolize trade, but that it was instead “for the purpose of maintaining the standards of medical practice.”²⁶⁴ The medical society stated that its motive was ethical, the government claimed, but it was truly economic. For example, MCMS was very clear about its economic motives when it approved the Multnomah Industrial Health Association, and these motives continued to remain especially apparent through the two organizations’ conflict over MIHA’s inclusion of teachers and other professionals who would have patronized society physicians were it not for the low prepaid rates. For all its objections to solicitation and advertising, the government’s brief went on, OSMS was very selective in its application of its own code of medical ethics: OPS actively solicited patients and advertised, and OSMS offered no objections. Finally, the medical society’s purported commitment to free choice of physician was a sham: OPS refused to include physicians who had been expelled from OSMS.²⁶⁵ Beyond that, a patient’s choice of physician was limited by financial constraints.

²⁶³ *United States v. Oregon State Medical Society*. Argued 1951. Brief for the United States, p. 2.

²⁶⁴ *Ibid.*, p. 152.

²⁶⁵ Recall that medical society membership was not a requirement for licensure to practice medicine under Oregon State law.

The second part of the government's argument concerned the medical society's authority to impose its private code of ethics on the medical services market, whether or not its motives were truly ethical. This part of the argument drew on both statutory and common law. On the statutory side of things, the government pointed out that OSMS had "not been appointed by the state authorities as law enforcement agencies to police the medical profession and eliminate all practices of which they did not approve."²⁶⁶ The legislature specifically delegated the authority to regulate hospital associations to the insurance commissioner. Absent legislative approval, actions in restraint of trade were not permitted under common law, the government argued. According to *Sugar Institute v. United States*, which concerned the sugar industry's attempt to deal with chaotic conditions through a "cooperative endeavor," businesses were not permitted to violate the provisions of the Sherman Act even to ameliorate "evils afflicting the industry..."²⁶⁷ The court's decision in *United States v. National Association of Real Estate Boards* (339 U.S. 485) further supported this point, the government contended. In that case, the Washington Real Estate Board fixed fees in reference to its own code of ethics. The court determined that such price fixing was an unreasonable restraint of trade, and that the worthiness of the end it served was immaterial.

The court unceremoniously rejected the government's arguments against the permissibility of OSMS's application of its code of ethics to the medical services market.

²⁶⁶ Ibid., p 153. Although this argument did not cite actual statutes, the appropriate source of law is statutory: only through statutes can the legislature delegate its authority in this manner.

²⁶⁷ Ibid, p. 155.

“We might observe in passing,” Justice Jackson wrote, “that there are ethical considerations where the historic direct relationship between patient and physician is involved which are quite different than the usual considerations prevailing in ordinary commercial matters.”²⁶⁸ Because medicine was distinct from ordinary commerce, the medical society’s imposition of its code of ethics on the medical services market was acceptable. The court cited the 1935 case of *Semler v. Oregon State Board of Dental Examiners* (294 U.S. 608) in support of its position. Concerning *Semler*, Jackson wrote, “This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession.”²⁶⁹

The court’s decision to cite *Semler* seems erroneous: the facts of *Semler* do not support the court’s application of its holding to *United States v. Oregon State Medical Society*. *Semler* concerned the validity of a 1933 Oregon statute regulating the professional conduct of dentists. Prior to 1933, Oregon law allowed the revocation of licenses for unprofessional conduct, defined as advertising in an untruthful or misleading manner. When the legislature passed the 1933 Act, it provided for additional grounds for revoking a license. Not only were misleading statements prohibited: a dentist could also lose his license for employing a solicitor, mounting “glaring light signs,” or advertising prices for professional services. A dentist brought suit against the Oregon State Board of Dental Examiners (OSBDE), seeking an injunction against the enforcement of the statute on the grounds that it violated his Fourteenth Amendment rights of due process and equal

²⁶⁸ *United States v. Oregon State Med. Soc’y*, 343 U.S. 326 (1952), p. 336.

²⁶⁹ *Ibid.*

protection, and that it impaired the obligation of contracts he had made with solicitors, in contravention of the Commerce Clause. The court quickly dismissed the equal protection and commerce clause claims, arguing that “the regulation of his conduct as a dentist is not an unreasonable exercise of the protective power of the state.”²⁷⁰

The court then went on to deal with the due process claim. The court asked whether the restrictions amounted “to an arbitrary interference with liberty and property...” In deciding this issue, it held that the regulations fell within the state’s police power.²⁷¹ This power extended beyond that which allowed the original anti-false advertising regulations. The court wrote,

And the community is concerned in providing safeguards not only against deception, but against practices which would tend to demoralize the profession by forcing its members into unseemly rivalry which would enlarge the opportunities of the least scrupulous. What is generally called the “ethics” of the profession is but the consensus of expert opinion as to the necessity of such standards.²⁷²

The key to the court’s conclusion was not that dentists were justified in applying their code on ethical grounds. Instead, the logic operated as follows: the legislature had the power to regulate on matters concerning general welfare, health, safety, and morals under its police power. Experts concluded that the code was necessary for preventing demoralization among dentists. Demoralization among dentists would injure the general

²⁷⁰ *Semler v. Oregon State Board of Dental Examiners*, 294 U.S. 608 (1935), p. 610.

²⁷¹ Police power refers to the power to regulate on matters concerning general welfare, health, safety, and morals. See: Richard Briffault and Laurie Reynolds, *State and Local Government Law* (West, 2010)

²⁷² *Ibid.*, p. 612.

welfare, health, safety, and morals of the citizens. Thus, the state had the power to apply the dentists' code of ethics within its regulatory framework.

The OSMS case was completely distinct from *Semler*. First, the dentists applied their code of ethics through the legislative process, whereas OSMS imposed it privately. *Semler* never legitimized private application. Second, the legislature actually delegated the power to regulate dentistry to OSBDE, a body composed of dentists. The legislature never delegated the power to regulate medicine to OSMS. Finally, the OSBDE enjoyed the power to revoke licenses, whereas OSMS did not. Any attempt by OSBDE to prevent entry into the market for the supply of dental services was legally sanctioned. The same did not apply to OSMS's attempts to control the medical services market through expulsions from the state and county medical societies.

In its holding in *United States v. Oregon State Medical Society*, the Supreme Court took a stance on the medical ethics issue that it had largely sidestepped in *American Medical Assn. v. United States*. In that case, the AMA, as defendants, urged the court to decide that a physician's practice of his profession did not constitute trade under Section 3 of the Sherman Act. The court refused to consider this question on the grounds that the Group Health Association was engaged in business, and thus the AMA violated the Sherman Act regardless of the nature of its own members' professions.²⁷³

²⁷³ *American Medical Assn. v. United States*, 317 US 519 (1943), p. 528. The *AMA* case had a special twist to it: Section 3 of the Sherman Antitrust Act allowed claims against practices within the District of Columbia. This case fell under section 3. The government would not have had a justiciable claim had the case fallen in any other jurisdiction, as the physician's actions did not implicate interstate commerce.

Thus, the court's holding in *United States v. Oregon State Medical Society* set a new precedent, and masked a slight deviation from its *Semler* decision.

Conclusion

April 28, 1952, marked the day when the Oregon State Medical Society's private sector approach to the hospital association issue gained complete legitimacy. The strategy, of course, had developed over two decades, and even had the court sided against the medical societies, the damage had already been done. The Supreme Court's opinion was, in many ways, unnecessary. It marked a departure from previous precedent, and the court could easily have sidestepped the issue. Nevertheless, the case marked an end to a decades-long dispute, and validated the physicians' private sector solution.

CHAPTER V

CONCLUSION

The medical services market that emerged in Oregon between the 1920s and the 1950s was not a free one. Although public statutes did not set strict rules for competition within that market, the market was free. Instead of being guided by public statutes, the market was ruled by a private code: the medical societies' private code of ethics.

Three factors contributed to the development of this privately-regulated market. First, key players in the contract medicine issue gave up on the legislative process as the means by which they could resolve their conflicts with the hospital associations. These groups' inability to form a stable coalition against contract medicine, their lack of internal cohesion, and the procedural rules of the Oregon state legislature contributed to the failure of a public resolution of the issue. Second, the Oregon State Medical Society succeeded in imposing its private code of ethics on the prepaid medical services market in the 1930s due to its increased internal cohesion and its ability to exploit the same legislative procedures that had previously stymied anti-hospital association efforts in the 1920s. Finally, the private sector solution was validated by the United States Supreme Court when it determined that the medical society's unique professional status exempted it from the rules that governed many other sectors of the private market.

In April, 2010, *The Economist* observed that Kaiser Permanente represented what it termed "another American way" to the provision of health care, compared with the United States' private fee-for-service and insurance model, or state medicine, with its

salaried, state-employed physicians.²⁷⁴ Kaiser's business model, in which salaried physicians serve as the employees of a not-for-profit business, is remarkably similar to that of the hospital associations of the 1920s and 1930s. The Permanente Foundation was one of the lucky survivors of OSMS's anti-hospital association strategy in the 1930s and 40s. One wonders if perhaps this model would not be an anomaly, and would not inspire such interest in the international news, had the medical societies not been so successful at imposing their private sector strategy.

²⁷⁴ "Controlling Health-Care Costs: Another American Way," *The Economist*, April 29, 2010, p.

APPENDIX

WORKMEN'S COMPENSATION HISTORIOGRAPHY

Historians analyzing the enactment of workmen's compensation statutes traditionally fell into two camps: materialists, including legal historian Lawrence Friedman and sociologist Jack Ladinsky; and idealists, including William Nelson, whose work on post-WWII accident law best exemplifies his school of thought.

Friedman and Ladinsky argued that the workmen's compensation statutes enacted in all states between 1910 and 1948 reflected social changes that led to a broad consensus marked by compromises between labor and capital. Charting American industrial development through the second half of the nineteenth century, they showed that technological and social changes eventually led to an "explosive growth of tort law," which could only be contained through the establishment of publicly-operated workmen's compensation funds. The advent of the industrial revolution in the mid-nineteenth century brought with it not only an increased use of heavy machinery, but also substantial growth in the number of injuries suffered by the employees who worked those machines. The existing legal system gave injured employees little recourse: under the "fellow-servant rule," an injured employee could not sue his employer for an injury caused by the negligence of a fellow-worker. Of course, there was little to gain in suing one's fellow employee anyway, and injured workers fell back on their own savings or private charity. Although draconian by twenty-first century standards, many nineteenth-century Americans saw the fellow-servant rule as a reasonable solution to the problems of industrial development. A rash of tort litigation against private industry would have

stifled national and regional economic development. Furthermore, the employees who performed the most dangerous tasks received higher compensation to offset the risks their jobs entailed.

Two key developments converged to undermine the fellow-servant rule. First, the rise of the contingent fee system made legal counsel available to injured workers who otherwise could not have afforded to sue. Under this system, the lawyer received no fee if the injured worker lost, but shared in the award if the jury found in favor of the plaintiff. Skillful lawyers and desperate workers banded together, won a substantial number of verdicts from sympathetic juries at the trial court level, and weakened key aspects of the fellow-servant rule in the appellate courts. Second, railroads became the target of popular anger. Granger legislatures passed regulations allowing injured employees to recover against railroads, and when federal regulations replaced ineffective state laws starting around 1887, safety rules found their way into the new codes. By 1893, Congress declared that the railroads could no longer hold their employees responsible for injuries incurred due to lack of proper safety equipment.

With the fellow-servant rule substantially weakened, businesses faced uncertainty and high legal costs. These increased legal costs came at a time when businesses were attempting to rationalize and bureaucratize their processes. However occasional, a large verdict in favor of an injured workman dramatically interfered with a business's financial planning efforts. Of course, injured workman benefited only marginally from the new legal circumstances they found themselves in. Court victories were far from certain, and successful plaintiffs were forced to split their awards with their lawyers. Perhaps at some

point in time, Friedman and Ladinsky reasoned, the tort system lost its usefulness, and led businessmen and laborers to pursue a new solution together. The workmen's compensation system resulted from that cooperation.

Under the new system, an administrative agency took over the role of the court, collected contributions to a workmen's compensation fund from employers and employees (the employers accounted for the greater share of the contributions), and dispensed those funds to injured workmen on the basis of well-defined statutory schedules. The award was small, but certain. Any injury sustained "in and in the course of employment" was compensable, even when the victim contributed to the accident through his own negligence. Workmen's compensation was essentially a compromise: labor gave up its chance at winning large, if only occasional, verdicts, and capital agreed to pay the majority of the compensation costs in exchange for financial stability and reduced legal costs. [Lawrence Friedman and Jack Ladinsky, "Social Change and the Law of Industrial Accidents," *Columbia Law Review*, 1967, vol. 67, pp. 50-82.]

William Nelson attacked the socio-legal approach that Friedman and Ladinsky took to the industrial accident problem. According to Nelson, this approach departed too far from even the slightly risky techniques that James Willard Hurst introduced when he chose to study not only judicial doctrines, but also "law in action" – namely, economic, social, and cultural developments. Friedman and Ladinsky, Nelson argued, "appear to go beyond Hurst" by treating "nineteenth century tort law as a product of judicial policy choice among various claims presented by competing interest groups." (Nelson, 123). Younger scholars committed even worse legal-historical sins, however, when they denied

the influence of judge-made doctrine altogether. Their mistaken approaches, Nelson argued, stemmed from their unwillingness to “recognize the unavailability of... direct evidence to answer the admittedly important questions they want to ask...” (Nelson, 123). Judicial opinions, Nelson believed, contained key insights that other historical sources did not.

Because judge-made doctrine had such an important influence on policy, Nelson reasoned, larger intellectual developments could find their way into those policies. Thus, he argued that policy saw a shift from fairness to efficiency as the main concern in the adjudication of tort cases, largely as an indirect result of the policies adopted by the U.S. military establishment during WWII. During the war, the military establishment’s assertion that exercise of care could significantly reduce casualties permeated the minds of millions of Americans, and led them in the postwar years to focus on how to deter civilian accidents. Thus, tort law came to center around problems of efficiency: the court would identify a socially optimal level of accidents. [William E. Nelson, “From Fairness to Efficiency: The Transformation of Tort Law in New York, 1920-1980,” *Buffalo Law Review*, Vol. 47, 1999, pp. 117-226.]

As an account of how intellectual factors directly influenced the enactment of workmen’s compensation statutes, Nelson’s work poses some chronological problems. Most of the current idealist interpretations of the history of tort law dance around the workmen’s compensation issue to a certain extent. Nevertheless, the theory that ideas influenced the birth of the state-managed workmen’s compensation system is a powerful one.

Legal historian John Fabian Witt, author of what has become the leading account of the history of workmen's compensation statutes, agreed with Nelson that laws reflect ideas. He also accepted Friedman's argument that law reflects social conditions. Thus, he posited an interpretation that incorporated both idealist and materialist aspects.

Solutions to the industrial accident problem of the late nineteenth and early twentieth centuries grew from American society's commitment to "free labor." Witt wrote, "the American accident problem was deeply bound up in a peculiar set of preoccupations borne of the American experience of slavery, civil war, and emancipation." (Witt, 22). Late 19th century developments threatened to upset the free labor ideal, but exactly how those developments did this was complicated by competing definitions of what free labor was. Liberals were committed to a definition of free labor centered on individual autonomy and "consensual relationships among autonomous private actors exercising... moral self-control..." (Witt, 34, internal quotation marks removed). Labor leaders, however, viewed free labor as a commitment to worker independence instead of individual autonomy. Free labor created the conditions under which the economically-independent worker could exercise his democratic rights. Managerial engineers (including Frederick Winslow Taylor) had yet another take: free labor generated the most efficient conditions for production. Finally, social science progressives saw free labor's benefits in its ability to preserve the "tranquility and virtue in the domestic sphere" by protecting the home and the worker's family from the vagaries of the marketplace. (Witt, 35).

The structure of the new American economy in the late nineteenth century threatened to undermine all of these ideals. Witt identified several ways in which this occurred, but the most important was the effect that the industrial accident crisis had on each conception of free labor. Each strand of free labor thought responded to the accident problem in its own way. Workmen's compensation was only one of these solutions, and its eventual enactment was hardly the inevitable product of material or intellectual developments.

Witt argued that tort law offered one possible solution to the accident problem in the liberal tradition. The reason that tort law was so effective was that it set up a barrier between the public and private spheres preventing the intrusion of government into the private market. The problem with this solution, however, lay in the nature of liberalism's definition of free labor as preserving the worker's autonomy: a worker freely exercising his rights could "generate causal ripples outside the actor's own sphere of autonomous action." (Witt, 46). Due to the structure of the new workplace, an individual action could set off an unforeseeable chain of events. This situation presented a dilemma: if the courts continued to apply a negligence standard in adjudicating tort claims, thousands of injured workers would be deprived of any legal remedy for actions caused through chains of events not necessarily caused by lack of due care on the part of the chains' initiators. If, on the other hand, the courts adopted a strict liability standard, holding individuals responsible for damages caused even when they exercised reasonable care, the state would be placed in a position whereby it invaded the private market and redistributed resources. Ultimately, as the United States' legal elite attempted to resolve this dilemma,

two factors emerged to undermine tort law as a solution to the accident crisis. First, a rise in personal injury litigation “pressed harder and harder on the weaknesses in the doctrine,” exacerbating an already-apparent lack of consensus especially prevalent among the lower courts (Witt, 51). Second, judges and scholars became increasingly aware that classical notions of fault failed to apply exactly to the industrial accident situation of the new economy. Ultimately, these two factors “precipitated a scramble for alternatives to the law of torts among working-class families seeking protections against the mounting risks of injury and death.” (Witt, 70).

Workingmen’s cooperatives offered another solution to the industrial accident problem, and served labor leaders’ conception of free labor as preserving the independence of the worker. Initially, the cooperatives were successful due to the face-to-face relationships between the workers: this allowed them to monitor other members’ behavior to deal with the adverse selection and moral hazard problems inherent to insurance pools. Three factors, however, converged to undermine the cooperatives. First, low-risk members ultimately fled the pools, leaving only older, higher-risk members putting strains on the funds. Second, developments in the law of insurance contracts harmed the cooperatives relative to commercial insurers. The latter could afford legal counsel to face courts which began to interpret contracts against the insurer. The former could not. Third, public perception of the cooperatives declined as fraud became rampant, especially among cooperatives attempting to take advantage of unsuspecting immigrant newcomers. Ultimately, Witt argued that the insurance cooperatives did not provide the winning solution to the industrial accident problem because they failed in the private

sector, and the state would not co-opt their structures as it did in Western Europe. The latter path never transpired for two reasons. First, the cooperatives' leaders resisted state regulation, largely to maintain their own positions. Second, political leaders were preoccupied with the industrial accident problem in the earliest part of the twentieth century, whereas the cooperatives served a much larger range of functions that the political elite had limited interest in (Witt, 76-99).

Managerial engineers offered a solution which offered to promote efficiency in the workplace, which scientific management saw as the primary benefit of free labor. Witt argued that the early twentieth century definition of efficiency valued conservation. Based on this value, managerial engineers concluded that accidents were wasteful and inefficient, and thus needed to be prevented. By accounting for the cost of accidents among production inputs, management promoted efficiency through incentives for prevention. These costs were those associated with firm-specific employee accident-compensation funds, which had the added benefit for legitimating the claims of managerial prerogatives necessary for implementing scientific management solutions. Witt argued that three factors converged to disadvantage the scientific management solution. First, the courts refused to enforce contract provisions barring employees from advancing tort claims against their employers. In other words, the courts refused to allow the scientific management solution to supplant the classical liberal solution to the industrial accident problem. Second, in a completely voluntary system, those firms which adopted employee benefit funds were placed at a disadvantage compared to those firms which refused to do so. Third, the plans were difficult to police (Witt, 110-125).

Social scientists offered the fourth and final solution, which ultimately manifested itself in the workmen's compensation system, and fundamentally reordered American law and social policy. By introducing statistical thinking to the accident problem, social scientists dragged the description of the problem away from one of direct causation toward one which relied on aggregates and averages. Thus, by abandoning fundamental aspects of free labor ideology and omitting individual actions from the problem statement, workmen's compensation was able to preserve what social scientists valued most about free labor ideology: the preservation of the family wage and the protection of the domestic sphere (Witt, 126-151). [John Fabian Witt, *The Accidental Republic: Crippled Workingmen, Destitute Widows, and the Remaking of American Law* (Cambridge: Harvard University Press, 2004).]

Mark Aldrich convincingly suggested that Witt failed to completely strike down the deterministic conclusions of the idealist and materialist investigations. As Witt himself pointed out, each of the three failed options – classical tort law, cooperative insurance, and employer relief organizations – faced its own inherent limits. Thus, Aldrich asks us, to what extent did the enactment of workmen's compensation reflect a free choice? Was its adoption merely dictated by the social and economic factors that limited the other three options, and left workmen's compensation as the only remaining solution? [Mark Aldrich, "Review of John Witt, *The Accidental Republic: Crippled Workingmen, Destitute Widows, and the Remaking of American Law*." EH.Net Economic History Services, Jun 11 2004. URL: <http://eh.net/bookreviews/library/0794>.]

Acknowledging these potential problems in Witt's work, the account still has a great deal of value. First, it stands for the principle that ideas have consequences. Especially to the non-historian, pursuing solutions to current-day problems without the benefit of hindsight, this principle is particularly compelling. Second, Witt introduced the argument that workmen's compensation was only one of four competing solutions. Where he fell short was in providing only a limited account of reordering processes that followed the enactment of the fourth and final solution. As the instant paper demonstrates, the scientific management approach to industrial accidents did not disappear overnight. Hospital associations and contract doctors adapted to the new workmen's compensation system in Washington and Oregon by working themselves into the official state system, and by continuing to offer additional benefits at a small additional cost. Likewise, fraternal benefit societies continued to hold out by advancing legislation to exempt themselves from the regulations imposed on other groups. Both strategies were facilitated in Oregon by the non-compulsory, non-monopolistic character of the State Industrial Accident Fund. Alternatives to state-directed workmen's compensation continued to exist, and the "losing" solutions continued to exploit them until the late 1940s and early 1950s when the Oregon State Medical Society ultimately succeeded in forcing the hospital associations out of the market for direct care.

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