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“Miracle And Wonder”: The AMA Embraces Quality Measurement

The American Medical Association’s recent quality initiatives show a marked departure from the organization’s historical views, says a long-time AMA watcher.

by Michael L. Millenson

Sitting on my desk are two clues about the very different ways in which the American Medical Association (AMA) approaches the topic of quality of care. The first piece of evidence is a glossy, silver-colored cardboard folder with the AMA’s name and logo tastefully embossed on the outside in green lettering. Inside the folder are materials about the American Medical Accreditation Program (AMAP), a recent AMA effort to establish a “uniform national quality standard” in assessing physician performance. To emphasize the scientific rigor of this endeavor, a press release lists the names of a distinguished expert consultant panel chosen “to assure the objectivity and resources necessary for the effort.”

The second piece of evidence is a quarter-page advertisement in the coveted lower right-hand corner of the 7 March 1997 New York Times op-ed page. The ad shows a smiling black female physician in white coat and stethoscope with her left arm around a smiling elderly white woman. The headline reads, “She’s my patient. There’s no way I’ll let anyone put a price tag on her life.” This ad, like the AMAP press release, is also about quality of care. Specifically, it asserts that the AMA’s plan for reforming Medicare is the best way to make certain that “costs cannot take precedence over necessary care and treatment,” thereby assuring “the highest quality of care available for all our patients.”

Anyone who deals for long with the AMA knows that it maddeningly combines the scientific, political, and economic. Some AMA policies are backed up by staff reports that involve thorough re-

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search and carefully documented conclusions. Others derive from a couple of physicians scribbling a resolution on a piece of paper in the back of the room and then persuading a majority of their colleagues in the AMA House of Delegates to vote “aye.” Like the U.S. Congress, the AMA’s House is nothing if not democratic.

The impact of AMA policies varies, too. On the one hand, the premier umbrella group for the nation’s doctors can act very much like “physicians dedicated to the health of America,” the slogan that the AMA added to its logo in 1990. (The AMA also changed its logo then as part of an overall image enhancement campaign: The thin and threatening serpent wrapped around the staff of Asklepios had its fangs removed. To make it look a little friendlier, the snake was made plumper, and a tiny smile was put on its face.) On the other hand, the AMA can and does act like any other interest group, out to get the most for its members. Interestingly, the “physicians dedicated to the health of America” line was missing next to the AMA logo in The New York Times ad. In its place was the slogan the AMA uses to boast to its own constituents about the group’s influence: “Today’s AMA. Giving Power to Your Voice.”

But what is that voice really asking for? As quality of care moves to the front of the political agenda, it is becoming more important than ever to assess the genuine contributions that organized medicine can make, without losing sight of the danger of allowing an interest group to define public policy. “Power to the patients” and “power to the physicians” are two distinct propositions, even if the AMA’s spin-meisters publicly profess “patient advocacy” as the basis for everything, from the AMA’s campaign against domestic violence to the nearly $9 million it spent on lobbying during the first half of 1996.

**Quality-of-care views in AMA history.** As a reporter for the Chicago Tribune, I covered the AMA from the early 1980s to the mid-1990s. More recently, as a visiting scholar at Northwestern University, I researched the organization’s history while writing a book on the effort to measure and manage the quality of care. I read through back issues of American Medical News (formerly The AMA News) from the publication’s inception in 1958, looking at what was written about quality of care from both the organization’s viewpoint and the viewpoints of individual AMA members.

The average doctor has defined quality of care in medicine very clearly: Pay me “fairly” (the doctor’s definition) and then leave me alone to practice the way I was trained. There is nothing inherently surprising about this. Most of us want the same from our jobs. What makes medicine different is the special nature of the doctor/patient relationship. Is it a “covenant,” or is it more like an economic contract: “You get what you pay for”? The answer depends on which
voices of organized medicine you listen to.

The first thing to remember about doctors is that they used to be poor, and the profession has never forgotten that vulnerability. Robert Martensen, writing in 1995 about the physicians of a century before, noted that like “blacksmiths, pharmacists, and plumbers,” they depended on collective action to raise their status and their income.¹ The AMA was part of that effort. One example was the group’s response to an attempt to reduce the fees paid to doctors for life insurance screening physicals. A large U.S. life insurer, reasoning much like a present-day preferred provider organization (PPO), thought that it deserved a discount because of the volume of patients it sent to doctors. A stinging editorial in the Journal of the American Medical Association (JAMA), reprinted by Martensen, warned the insurer that reducing doctors’ fees invited doctors to provide reduced medical vigilance on behalf of policyholders.² Commented Martensen: “While the factors contributing to current anxieties differ from those in 1895, complaints of a similar tone are once again rife.”

In fact, that economic anxiety never went away, nor did the AMA’s role as protector of the physician’s pocketbook (albeit in the name of “medical vigilance”). The trick was to link reimbursement to appropriate professional services. During the Great Depression, a third of all physicians eked out a living on incomes below the poverty line.³ After World War II, when a physician shortage and the advent of “wonder drugs” caused a boom in demand for doctors, the AMA found itself in the awkward position of trying to rein in members who were hell-bent on making up for the years of deprivation. The AMA leadership launched campaigns to persuade doctors to give up the all-too-common practices of taking kickbacks from laboratories, pharmacies, and eyeglass makers. Separately, the American College of Surgeons remained locked in its decades-long struggle against “fee-splitting,” in which a surgeon rewarded the referring doctor by kicking back part of the patient’s payment. The college was also trying to curb “ghost surgery,” where a surgeon secretly subcontracted the actual operation to a different doctor. The first surgeon charged the patient a fee, paid the “ghost” a lower one, and then pocketed the difference.

A candid report by an AMA special committee on medical practices, accepted by the House of Delegates at the 1955 meeting, painted this picture of the profession:

Most of the doctors interviewed display a consistent preoccupation with their economic insecurity. They think about money a lot—about how to increase their incomes, about the cost of running their offices, about what their colleagues in other specialties make, about what plumbers make for house calls and what a liquor dealer’s net is compared to their own.⁴

As the head of the AMA’s bureau of medical economic research...
acknowledged to a *Wall Street Journal* reporter in 1956: “The doctor is essentially a small businessman. He is selling his services, so is as much in business as is anyone else who sells a commodity.”\(^{5}\) Indeed, the AMA created its bureau of economics at least three decades before the establishment in the early 1960s of a department of continuing medical education.\(^{6}\)

**So-called golden age of medicine.** Today many doctors speak about a “golden age” of medicine that supposedly existed in the pristine fee-for-service days before Medicare, Medicaid, utilization review, and managed care. The theory is that physician autonomy allowed doctors to concentrate on caring for patients instead of worrying about pettifogging paper requirements. That is akin to believing that the 1950s were a golden era for pharmaceuticals because the Food and Drug Administration had not yet required tedious clinical trials to demonstrate that a drug was effective.

While we hear many stories today about greedy managed care companies, it is instructive to review the media coverage from the era when the power of the doctor to order any treatment he or she wished was virtually unchecked. For example, the headline of a 30 October 1953 article in *Collier’s* advised: “Why Some Doctors Should Be in Jail.” “The M.D.’s Are off Their Pedestal,” said a February 1954 piece in *Fortune*. That same month, *Harper’s Magazine* praised the “conservative” surgeon and warned its readers of the danger of the “commercial” surgeon who was “usually a good salesman,” liable to make a diagnosis such as “chronic remunerative appendicitis.”\(^{7}\)

The AMA’s scientific arm provided plenty of evidence of problems. One of the most dramatic examples presented a horrifying picture of casualness about a procedure that takes away a woman’s ability to bear children.\(^{8}\) In reviewing the records of more than 6,000 hysterectomies in thirty-five hospitals, physician James Doyle found hundreds of women who had received either no preoperative diagnosis or a simple diagnosis such as “pain.” Postoperatively it turned out that 30 percent of all of the patients ages twenty to twenty-nine who were subjected to hysterectomy had no disease whatsoever, a number that Doyle rightly called “appalling.”

In a searing 1958 exposé, award-winning journalist Richard Carter wrote: “The medical profession receives about thirty cents for every one dollar spent by American families for care of their health, but, except where felony or demonstrable malpractice are concerned, it remains sole arbiter of the quality and quantity which it gives in return. In no other area of modern life is the vendor of an indispensable service so free of social restraint.”\(^{9}\)

Social restraint, not self-restraint, is what eventually curbed medical abuses. At the end of the 1960s, 90 percent of Americans
were covered by some form of public or private health insurance that reimbursed on a fee-for-service basis. Yet rather than this producing happiness and good health all around, public dissatisfaction with the U.S. health care system was rampant. Liberals and conservatives disagreed only on the cure, not on the diagnosis. An editorial in the January 1970 issue of *Fortune* concluded, “Much of U.S. medical care . . . is inferior in quality, wastefully dispensed and iniquitably financed. . . . [T]he time has come for radical change.”10 As Medicare and private insurance costs soared—thanks to physicians’ ability to charge “usual and customary” fees—John G. Veneman, undersecretary of the Department of Health, Education, and Welfare (HEW) in the Nixon administration, summed up a turning point in health policy: “In the past, decisions on health care delivery were largely professional ones,” he said. “Now, the decisions will be largely political.”11

**Government intervention.** It was, in other words, the dismal failure of professional self-control that led to government intervention—just as is now happening with managed care. In 1965, for example, the AMA had made certain that Medicare legislation prohibited direct government oversight of care. However, the law did say that hospital medical staffs had to set up utilization review committees to ensure that the elderly received appropriate treatment. But half of all hospitals never bothered to comply, a 1968 government survey found.12 Congress responded with a more detailed federal mandate to oversee cost and quality, first by professional standards review organizations (PSROs) and then by peer review organizations (PROs) some years later. In 1974, meanwhile, a House subcommittee held the first hearings on inappropriate surgery and concluded that the number of unneeded procedures had grown about 20 percent since a 1966 exposé, *The Doctors*, had charged that there were two million unnecessary operations.

As late as 1969, the governors of sixteen states picked the members of medical licensure boards who oversaw medical quality from a list helpfully provided by the state medical society.13 During the 1970s states started to mandate at least nominal representation from the general public. At the beginning of the 1970s, thirty-two states had laws, based on the AMA Code of Ethics, that banned “information that would point out differences between doctors.” In 1975 a Supreme Court decision ruling that professional societies were subject to antitrust lawsuits for restraint of trade spelled the beginning of the end for that kind of legislation.14

**Hospital accreditation.** Hospital accreditation had always been based on “minimum standards.” In the early 1970s, public concerns about quality forced the AMA and the American Hospital Association (AHA) to completely overhaul the Joint Commission on
Accreditation of Hospitals (since renamed the Joint Commission on Accreditation of Healthcare Organizations [JCAHO]). In theory, the new JCAHO “medical audit” required measurement of medical outcomes at hospitals. In practice this promise was never kept. Still, standards were improved, and in 1997 the JCAHO rolled out “Oryx,” its latest version of an outcomes management system.

Struggle for control. The AMA struggled to adapt to this new, more critical environment. In 1967 the surgeon general of the United States, William Stewart, openly called U.S. medical care “often of low quality, fragmented and impersonal.” Yet, at the AMA’s 1968 convention, the six principles approved by the House of Delegates as essential to providing “the people of the nation with the highest quality of medical care” were all linked in some way to economics. Like generals obsessed with refighting the last big war, the AMA seemed to always see various forms of “socialized medicine” (a catch-all phrase for anything from Medicare reviewers to national health insurance) as the biggest threat to quality. A 1934 AMA House of Delegates resolution had declared: “All features of medical service in any method of medical practice should be under the control of the profession. No other body or individual is legally or educationally equipped to exercise such control.” Successive generations of doctors felt precisely the same way. Maximum physician autonomy was still the foundation of good medical treatment. Any other stance by the AMA was usually a tactical one, not a strategic shift, at least in the eyes of the grassroots membership.

So, for instance, the AMA supported passage of the Health Maintenance Organization Act of 1973, but only as a way to stave off the liberal mob calling for national health insurance. It was not until 1992 that AMA Executive Vice-President James Todd would attend a meeting of the chief HMO trade association and formally acknowledge the equal legitimacy of prepaid care and fee-for-service practice. For his trouble, Todd received a torrent of letters from AMA members calling on him to resign.

And although in 1979 the AMA House “strongly endorsed efforts to develop quality assessment methods based on patient outcomes,” it added a coda that it opposed “preset guidelines for appropriateness of care.” PSRO guidelines should also be “local” rather than “federal” when judging appropriate care, the AMA House said.

Is it any wonder that the AMA’s announced commitment in 1984 to reduce regional practice variations—a commitment made shortly after former Wisconsin Senator William Proxmire held hearings highlighting John Wennberg’s research on the topic—went nowhere? Voluntarism was clearly linked to fear of federal intervention, as delegates to the AMA’s 1984 interim meeting warned that
“efforts to eliminate regional variations through economic incentives may have a negative impact on quality of care.” Unfortunately, history has shown that efforts to eliminate practice variations without any economic incentives have little impact. To sustain voluntarism one needs an atmosphere that encourages voluntarism to continue. A “clinical appropriateness initiative” involving the AMA, RAND, and the Academic Medical Center Consortium, announced with great fanfare in 1990, eventually fizzled as “public interest and congressional pressure subsided,” one insider told me.

I would be willing to bet that your average HMO executive, influenced by the same capitalistic incentives the AMA used to praise, eliminates more inappropriate care in a month than the cooperative effort of the AMA and its partners was able to do over several years.

The AMA worshipped so completely at the altar of “autonomy” that the group could not even bear to use the word “guidelines” when it finally became involved in the late 1980s in coordinating guideline development. Instead, the AMA invented the phrase “practice parameters.”

■ The “new AMA.” Yet, the 1980s also brought signs of a “new AMA” (the group’s own phrase). While the AMA’s House of Delegates continued to prove that you only need a simple majority to endorse simplistic thinking (a topic for a whole separate article), its scientific and policy arms became more sophisticated. To be sure, the cry of “rationing” was still heard whenever the federal wallet threatened to close. James Sammons, the AMA executive vice-president in 1984, initially denounced the prospective payment system (PPS) by telling The New York Times: “[Doctors] are really worried that they’re not going to be allowed to practice medicine as they know it . . . based on their own judgment. . . . Financial restraints have led to the rationing of health care.” In 1989, when President George Bush proposed “expenditure targets” to control Medicare costs, Sammons had the AMA play the same tune. The ads that appeared in The New York Times and The Washington Post showed a bleak picture of an elderly woman and asked: “How Do You Tell Someone on Medicare She’s an ‘Expenditure Target’?” The present-day AMA ads are a bit more subtle, but they still tell politicians that it is patients, not doctors’ pocketbooks, that will get hurt unless the group’s voice is heard.

■ New approach to quality of care. Nonetheless, by the 1980s the AMA’s scientific arm was beginning to show the political leadership a better way to define quality of care. JAMA began printing a regular column by David Eddy on clinical decision making and provided a forum for the work of Donald Berwick and many other researchers on clinical quality improvement. The 22/29 August 1986 issue of the journal was the first issue of a major clinical publication
“While skepticism about the AMA’s latest efforts is justified, as its previous history makes clear, so, too, is a degree of optimism.”

to be devoted completely to quality measurement and management, and the journal never looked back from there. In 1997 each AMA scientific publication is scheduled to have a quality theme issue.

About the time of that 1986 issue, I asked then AMA Deputy Executive Vice-President James Todd about objective measures of quality. He replied that they were elusive, and he paraphrased a famous Supreme Court opinion about pornography to show that doctors could still safeguard their patients. When it comes to recognizing good care, “I know it when I see it.” But when I asked JAMA editor George Lundberg the same question, he responded very differently: “The single most important thing that American medicine . . . should do is define quality indicators and follow them.”

Quality, in other words, was something that could be objectively measured and systematically improved. It did not simply flow mysteriously from the presence of a doctor who graduated from an accredited medical training program.

The American Medical Accreditation Program is a direct result of the groundwork laid by Lundberg. It recognizes that the world has changed. For physicians to maintain their cherished autonomy—or what is left of it—they must respond to the legitimate concerns of the outside world. And so, AMAP is designed to be “universally accepted by hospitals, insurers and other organizations” as a “standard of excellence.” It evaluates five important areas: (1) physician credentials and work histories; (2) personal qualifications, such as agreement to abide by the AMA principles of personal ethics; (3) the work environment in the doctor’s office, including clinical and management systems; (4) patient care results, including patient satisfaction surveys; and (5) actual clinical performance measured against a national benchmark. Physicians who make the grade, or who show steady progress toward it, will be granted the AMAP seal of approval. Doctors who can’t cut the mustard will not be shielded from the consequences by their AMA membership card.

As if AMAP were not enough, the AMA is also aggressively pursuing a review of clinical practice guidelines—and is even using the word “guidelines.” An AMA stamp of approval is being awarded to those recommendations that are well grounded in scientific evidence. Moreover, the AMA is sponsoring the establishment of a national foundation whose mission is to help doctors to reduce the number of treatment-related injuries and deaths.
“If you had told me five years ago the AMA was doing what it’s doing today, I’d have said, ‘Not in my lifetime,’” concedes William Jessee, who joined the AMA staff in early 1996 as its vice-president for quality and managed care. “But the organization has changed, because the environment has changed…. I think the board committed to the fact that this scares the bejeesus out of us, but we’re going to do it.”

Of course, the true test of a commitment lies in how well it is carried out. Yet, while skepticism about the AMA’s latest efforts is justified, as its previous history makes clear, so, too, is a degree of optimism. The AMA stamp of approval on a guideline or a doctor’s office practice may or may not guarantee medical excellence, but it most certainly signals the legitimization of guidelines and of performance review. That is a milestone whose significance should not be underrated. Like former President Richard Nixon going to Red China, the symbolism of the AMA actions has value. And like Nixon in China, the AMA traveled a very long road to arrive at this point. When the AMA says that “patients will benefit from the greater certainty and lower costs that uniform standards will bring,” it is, in fact, speaking with a “pro-patient” voice—depending, of course, on the standards.

■ New approach to medical error. The AMA also is to be commended for apparently embracing science over ideology in its new approach to medical error. The AMA’s response to the spate of medical mistakes that captured headlines in early 1995—the wrong foot cut off a diabetic; the drug overdose that killed Boston Globe reporter Betsy Lehman—was essentially to dismiss the problem. “There are more than nine million physician/patient encounters every day in America,” wrote then AMA President Robert McAfee in a soothing letter to the editors of some 200 newspapers. “An extraordinarily high percentage are positive. Some are miraculous. But isolated and sometimes egregious mistakes also occur.” That political response appeared highly questionable in light of the articles that had appeared only a few months before in the AMA’s own flagship scientific journal.

In a December 1994 issue of JAMA, Lucian Leape, a physician at the Harvard School of Public Health, specifically singled out professional complacency as a major reason why the number of medical mistakes has not been reduced: “Although error rates are substantial, serious injuries due to errors . . . are perceived as isolated and unusual events—‘outliers.’”

Equally blunt was an accompanying commentary in the same issue by David Blumenthal, also a Harvard researcher and clinician. Carefully labeled like all AMA journal editorials as not representing official AMA policy, the editorial declared: “Concerning medical error and its prevention, the profession has, with rare exceptions,
adopted an ostrichlike attitude. . . . Mistakes have been treated as
uncommon and atypical, requiring no remedy beyond the tradi-
tional. . . . [But a] large and growing collection of literature demon-
strates that physicians’ approaches to the management of medical
error do not work well enough.”

Apart from the journal articles, an AMA scientific committee had
issued a report to the AMA board specifically dealing with medica-
tion errors. The report—accepted at the 1994 AMA annual meet-
ing—concluded that medication errors “are not rare events . . . and
they compromise the confidence of patients and the general public
in the health care system. Fortunately, most medication errors are
preventable.”

The AMA got away with these contradictions. No one in the news
media or in the scholarly community pointed them out. Yet, as with
the AMA’s latest approach to guidelines, the organization seems to
have changed. Martin Hatlie, director of the AMA’s department of
professional liability and patient safety and executive director of the
new National Patient Safety Foundation, responded frankly to my
questions about the AMA’s ambiguous position on medical mistakes.
“People here were asking the same question—‘Where is the consis-
tency?’,“ Hatlie acknowledged. The AMA board, continued Hatlie, is
trying to set a new course. “We’re going to go forward and认可
ledge as we haven’t before that Lucian Leape was right, and that
whatever the number, . . . errors are a problem. We are professionals.
We have to do what’s right. Physicians are accountable.”

Whether these attempts to be an honest broker will win accep-
tance remains to be seen. The AMA is trying hard to demonstrate
that it has changed. AMAP is at least putatively an attempt to im-
prove managed care, not eliminate or undermine it (even if the AMA’s
political arm continues to push anti–managed care legislation).
Moreover, the AMA has added consumer, business, and managed care
representatives to the AMAP board. Similarly, the AMA-initiated Na-
tional Patient Safety Foundation is seeking a partnership with other
medical and nonprofit organizations.

Medical “miracles.” Back in 1986 a Paul Simon album entitled
Graceland contained a popular song whose refrain went: “These are
the days of miracle and wonder.” The song referred to the kind of
medical miracles that always seem to show up on the nightly
news: “Medicine is magical and magical is art/The Boy in the
Bubble/And the baby with the baboon heart.” In reality, though,
very few patients ever require that level of magical artistry. There are
a handful of children who need an isolation bubble or who are eligi-
able for a baboon heart. On the other hand, there are millions of
Americans whose lives will be improved—maybe even saved—if
quality-improvement efforts ensure that they get the most appropriate and effective treatment available.

The dominance of managed care in our health care delivery system has destroyed any pretense that unrestrained physician individualism is a viable model for medical excellence. That realization has been a long time in coming. A former AMA president noted: “Until recently, people... rested content because medicine is in good hands. But the unprecedented growth of medicine, the enormous expansion of personnel and facilities, the investment of billions of dollars have created issues from which society cannot escape merely through its own optimism or through confidence in the high character of medical practitioners.”

Ray Lyman Wilbur, chairman of the Committee on the Costs of Medical Care and a member of President Herbert Hoover’s cabinet, wrote those words in 1933.

If the AMA’s newest quality initiatives help physicians to understand and use continuous quality improvement, evidence-based practice guidelines, and outcomes measurement, the public will owe the AMA a debt of gratitude. Credibility, however, needs to be earned on the basis of achievement. The AMA must prove that it will live up to its commitments. Meanwhile, the public and policymakers should ensure that the social, political, and economic environments make it easy and advantageous for the AMA to keep its promises.

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NOTES

16. “Editorial Viewpoint: Ensuring Quality Care,” *The AMA News*, 3 February 1969. The six principles adopted at the 1968 AMA meeting and listed in the editorial included responsibility for care (the individual should try to pay for him or herself); role of physician (doctors should charge reasonable fees, or no fee if the patient is too poor); quality medical care (the patient should be able to select any doctor he wishes; the doctor should be free to select his patients and select the therapy that is the most beneficial); payment of usual, customary, and reasonable fees (the AMA favored this payment method); administration of programs (administrative procedures should be simple); and assistance of physicians and medical societies (the societies should help the government to administer its medical programs).
25. American Medical Association, “Report of the Board of Trustees on Medication Errors in Hospitals” (Submitted to the AMA House of Delegates at the AMA annual meeting, Chicago, June 1994). The report is a public document and was contained in the annual meeting handbook given to AMA delegates and the news media. Board reports are automatically accepted; only if a report contains recommendations is it voted on. The reports are filed for information purposes but are not considered official AMA policy.
27. Falk et al., “The Costs of Medical Care.” For the sake of readability, various sentences in the foreword on pages v–x are compressed together without the traditional ellipses separating omitted words or sentences.