

Iowa Physicians:
Legitimacy, Institutions,
and the Practice of Medicine

Part Three
Dealing with Poverty
and Defending Autonomy, 1929–1950

SUSAN C. LAWRENCE

IN JANUARY 1933 Dr. Oliver J. Fay, a general surgeon in Des Moines who chaired the Iowa State Medical Society's Board of Trustees, addressed the Polk County Medical Society with his thoughts on the *Final Report of the Committee on the Costs of Medical Care*. That controversial report, the product of five years of research by an amply funded interdisciplinary group, was highly critical of medical care in America. Too many Americans did not have access to physicians, the report asserted, and even when they did, too many could not afford what they needed.

In Part 1 of this series, I expressed my gratitude to all of those who initiated this project, provided research help, and offered helpful comments in its formative years. In Part 2, I thanked, with deep appreciation, the librarians, archivists and staff of the University of Iowa and the State Historical Society of Iowa. In addition to all of those individuals, I am grateful to John Fry for inviting me to the Newberry Library Seminar in Rural History, where I received very helpful feedback on part of this article. Among the many people whose conversations have stimulated rethinking, revisions, and rewriting, I particularly thank Marilyn Olson and Angela Keysor.

THE ANNALS OF IOWA 66 (Winter 2007). © The State Historical Society of Iowa, 2007.

The recommendations of the majority, made up of economists, lawyers, sociologists, public health experts, and physicians, were hardly radical by twenty-first-century standards. The committee contended that public health services needed to be expanded to ensure safe water and milk supplies, proper community sanitation, and adequate control of communicable diseases. The majority members also maintained that medical services should be provided by coordinated groups of physicians, nurses, dentists, pharmacists, and assistants, rather than by independent, solo practitioners, in order to increase efficiency and efficacy in the delivery of health care. The report urged, moreover, that “the costs of medical care be placed on a group payment basis,” using pre-payment insurance premiums and tax revenues, rather than centered on private, fee-for-service cash transactions arranged individually between the physician and the patient. With the support of public health services, “we can have no quarrel,” Dr. Fay admitted. The other recommendations of the report he denounced. They spelled doom for American medicine, for every physician’s independence and individualism. Dr. Fay concluded his essay with a ringing call for the physician’s “right to carry on unshackled by bureaucratic control.”¹

By the early 1930s, the very success of the professional and political changes that had taken place in the state since the 1850s had put great strains on physicians’ autonomy and individualism. As discussed in part one (1850–1886) of this three-part study, in the first decades of statehood Iowans sought medical

1. *Medical Care for the American People: The Final Report of the Committee on the Costs of Medical Care* (Chicago, 1932); Oliver J. Fay, “A Discussion of the Final Report of the Committee on the Costs of Medical Care,” *Journal of the Iowa State Medical Society* (hereafter cited as *JISMS*) 23 (1933), 117, 120, 125. The full committee, which varied over the five years of the project, had more than 50 members. Several minority reports were included in the final publication, where various constituencies dissented from some of the recommendations. Dr. Fay’s criticisms echoed those of seven of the private practice physicians on the committee, who, together with two other members, produced a strongly worded minority report against group practice and any type of medical insurance. There were 15 private practice physicians on the committee, however, so seven of those doctors, along with eight other MDs in public health or institutional positions, agreed with the majority report. Paul Starr, *The Social Transformation of American Medicine* (New York, 1982), 261–66; Forrest A. Walker, “Americanism versus Sovietism: A Study of the Reaction to the Committee on the Costs of Medical Care,” *Bulletin of the History of Medicine* 53 (1979), 489–504.

care from a diverse range of practitioners who competed with each other for patients free from the “bureaucratic control” of state licensing laws. Among the groups with differing therapeutic philosophies, only the regular, eclectic, and homeopathic doctors had active leaders who launched medical schools, created medical societies, lobbied for public health measures, and supported, for the most part, the building of state-funded institutions for the insane and other medical unfortunates. It took until 1886 for doctors to put aside their disputes long enough to push a medical practice act through the state legislature, giving bureaucratic control of medical licensing to a state board of medical examiners.² In those decades, at least some Iowa physicians learned the power of collective action and political maneuvering in their efforts to establish legitimacy. Most practitioners, nevertheless, had probably just gone about their business: seeing patients, dealing with illnesses and traumas, and trying to make a decent living.

Between 1887 and 1928, the promises of scientific and technological innovations significantly changed the practice of medicine. Part two (1887–1928) covered the way Iowa’s licensing law gave the State Board of Medical Examiners the power to reshape medical education, leaving the state with only one regular medical school, at the University of Iowa, in 1913. Bacteriology became the poster child for the value of laboratory science to understand and, in some cases, to actually prevent and treat life-threatening infectious diseases. The discovery and spread of x-ray imaging in medicine similarly epitomized the technological wonders of medicine made modern. The number of hospitals across the state grew dramatically, from 21 in 1890 to 175 in 1930, as the preferred places for surgical operations shifted from homes to operating theaters. Physicians became increasingly dependent on access to laboratory tests, x-ray machines, and hospital facilities when caring for their patients, and increasingly felt pressured to keep up with the deluge of information coming out of research laboratories and from the pens of prominent practitioners. The staunchly individualistic country doctor

2. Susan C. Lawrence, “Iowa Physicians: Legitimacy, Institutions, and the Practice of Medicine,” Part 1, “Establishing a Professional Identity,” *Annals of Iowa* 62 (2003), 151–200.

who relied only on his own experience with time-tested remedies was no longer a quaint eccentric, no matter how beloved; he started to be dangerously old-fashioned. Members of the Iowa State Medical Society (ISMS) worked hard to encourage all Iowa physicians to attend meetings of their county medical societies, sign up for postgraduate courses, read medical journals, and adapt to the collective wisdom of experts and specialists – a push that continued from 1928 to 1950. On the political side, state legislators in Iowa generally supported the growth of hospitals and the development of public health efforts in those decades, but they by no means slavishly followed mainstream medicine’s wish list. Licensing acts for osteopathic physicians (1902) and chiropractic healers (1921), for instance, upset ISMS members, who discovered that their claims to scientific authority in medical matters did not persuade Iowans to renounce alternative practices.³

This article, the last of this three-part series, briefly lays out some of the major changes in medical organization and institutions in Iowa between 1929 and 1950. The bulk of the essay then focuses on the effects that the rising costs of medical care had on ordinary Iowa physicians. Anxiety about the expense of medical services for the respectable working and middle classes joined worries about paying for the basic health needs of the indigent and marginally poor. In the 1910s and 1920s, more physicians and more patients expected hospital stays for surgery and childbirth, looked to laboratory-based tests for diagnostic information, and required office visits for vaccinations, health checkups, and ongoing monitoring of treatments, and all of these cost money. These changing standards of medical care had already started to reshape the meaning of access to adequate medical practice, especially in rural areas and among lower income groups, by the late 1920s.⁴ The disjunction between what scientifically trained physicians could provide and what people perceived they could afford, along with the widen-

3. Susan C. Lawrence, “Iowa Physicians: Legitimacy, Institutions, and the Practice of Medicine,” Part 2, “Putting Science into Practice,” *Annals of Iowa* 62 (2004), 1–62.

4. Clive A. Henry, “Green Fields of the Country Practitioner,” *JISMS* 19 (1929), 95–102.

ing gap between professional knowledge and common lay understanding of health and disease, led to a widespread crisis of confidence in the traditional fee-for-service, individualistic system of private medical practice. The worsening of the Iowa economy in the late 1920s and the national depression throughout the 1930s turned the problem of medical care for the poor and for those on the margins of solvency into a major issue for Iowa doctors.

Until the early 1930s, dealing with the poor in America was almost entirely a local responsibility: local governments (counties, towns, and cities) and charities (lay and religious) provided the food, clothing, shelter, medicines, and therapies that kept most of those in dire straits from dying in the streets. With the onset of the Great Depression, the local, customary, and ad hoc ways of dealing with medical neediness stopped working. Infusions of federal and state funds into local governments after 1934 brought much needed help, yet also brought state-level expectations for the oversight and accountability of money spent on health care. Iowa's economy recovered during World War II, as did the nation's, but debates about health care costs and services became even more heated. In the years immediately following the war, many Americans hoped that private, employer-based health insurance would expand to fill citizens' needs for protection against the costs of catastrophic, poverty-inducing illnesses and traumas. In Iowa, as in other states, physicians who objected to commercial insurance companies taking on health care coverage reluctantly agreed to form a non-profit, physician-controlled plan organized at the state level. The Iowa State Medical Society essentially created the Iowa Medical Service (Blue Shield) in 1945–46. Iowa physicians pushed the Iowa Medical Service plan as a viable, and better, alternative to a federally funded, universal-coverage national health insurance program when arguing against various bills that went to Congress in the late 1940s. Responsibility for medical care for the poor largely returned to county governments, with some state oversight and state-funded programs, until the 1960s.

Quite a few historians have written on twentieth-century American health care politics and policies from a national, and

predominately urban, viewpoint.⁵ Their work certainly informs this study of the history of medicine in Iowa. I argue, however, that examining health care politics at the state and county level, particularly in a rural, agricultural state such as Iowa, offers a vital perspective on the dynamics of national politics, because so many of the day-to-day experiences that physicians had with “government” medicine first took place at the county level.⁶ Physicians had to deal with those in need in their own communities at the same time that they competed with each other for paying patients. Appreciating how physicians throughout Iowa discussed medical politics and reacted to payment plans run by non-physicians helps us to understand how and why organized medicine—seen so clearly at the national level of the American Medical Association (AMA)—became such a powerful economic and political force in American society in the 1930s and 1940s.

Concentrating on “organized medicine”—medicine seen through institutional data, meeting reports, and items printed in the *Journal of the Iowa State Medical Society*—obviously misses a great deal.⁷ Much more work is needed on the ways people experienced health needs in Iowa, interacted with physicians, used hospitals, and expected—or not—that new scientific and

5. Among the most important works on the complexities of medical politics and economics in American history are Starr, *Social Transformation*; Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America* (Princeton, NJ, 2003); Beatrix Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America* (Chapel Hill, NC, 2001); and Ronald Numbers, *Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912–1920* (Baltimore, 1978).

6. Michael R. Grey makes the same argument in his excellent study, *New Deal Medicine: The Rural Health Programs of the Farm Security Administration* (Baltimore, 1999). Grey focuses particularly on states with large FSA programs, especially North Dakota and South Dakota.

7. In addition to the lacunae mentioned in the text, note that several social movements that involved physicians and medical care in Iowa have been omitted from this discussion. Among these, one of the most important is the eugenics movement in Iowa. See Amy Vogel, “Regulating Degeneracy: Eugenic Sterilization in Iowa, 1911–1977,” *Annals of Iowa* 54 (1995), 121–43. For discussions of eugenics in the *JISMS*, see “Legalized Eugenic Sterilization,” *JISMS* 25 (1935), 155; “Report of Special Committee on Eugenics,” *JISMS* 11 (1921), 278; “Sterilization of the Unfit,” *JISMS* 19 (1929), 127–28; Eleanor Hutchinson, “Possibilities for Race Betterment,” *JISMS* 24 (1934), 577–80; Willard C. Brinegar et al., “Sterilization of Patients Discharged from Four Iowa State Hospitals in 1947,” *JISMS* 40 (1950), 263–64.

medical discoveries would make a difference in their lives and deaths. National studies on “average” health care costs in the 1930s and 1940s may provide interesting figures, but such data are useless for understanding the choices that rural and urban Iowans made about health care. Alternative, unlicensed healers did not disappear just because Iowa had medical practice acts. Drugstores carried scores of over-the-counter remedies that offered relief without the bother of seeing a doctor, and Iowa saw its share of entrepreneurs promising dubious cures.⁸ The sources used for this article amply document Iowa physicians’ complaints about these treatment options, but doctors’ grumblings give poor estimates of the extent and seriousness of Iowans’ engagement with self-help and irregular practitioners in these decades. Similarly, passing notices and references suggest that public health campaigns to spread information about contagious diseases, to inform people about the importance of early detection of cancer, and to get schoolchildren in for health checkups all depended on armies of volunteers and community organizations; their local efforts deserve further analysis.⁹ Articles in the

8. Eric S. Juhnke, *Quacks and Crusaders: The Fabulous Careers of John Brinkley, Norman Baker and Harry Hoxsey* (Lawrence, KS, 2002), 36–63, details Norman Baker’s claims to cure cancer at his hospital in Muscatine in the early 1930s; James C. Whorton, *Nature Cures: The History of Alternative Medicine in America* (New York, 2002), provides a useful overview of alternative healing movements. For the popularity of over-the-counter dietary supplements following the discoveries of vitamins, see Rima D. Apple, *Vitamania: Vitamins in American Culture* (New Brunswick, NJ, 1996).

9. Laura Gellott, “Visiting the Rural Community: A Public Health Education Program in the 1930s,” *Mid-America: A Historical Review* 69 (1987), 21–38; Mrs. Fred Moore, “The Women’s Auxiliary to the Iowa State Medical Society,” in *One Hundred Years of Iowa Medicine: Commemorating the Centenary of the Iowa State Medical Society, 1850–1950* (Iowa City, 1950), 427–29. The women’s auxiliary had a regular news page in the *IISMS* after 1936. Most historical work on women’s clubs to date focuses on the years before 1930 and deals largely with education, libraries, or political activism rather than local health concerns. See, for example, Anne Firor Scott, *Natural Allies: Women’s Associations in American History* (Urbana, 1991). Gerald Gamm and Robert D. Putnam, “The Growth of Voluntary Associations in America, 1840–1940,” *Journal of Interdisciplinary History* 29 (1999), 511–57, point out that voluntary associations after 1910 were particularly strong in “the hinterland” (514) rather than in large, urban areas, where voluntarism actually declined. A few national-level histories of voluntary health organizations have been written, and they could provide useful starting points for further research on local efforts. See, for example, Walter S. Ross, *Crusade: The Official History of the American Cancer Society* (New York, 1987).

ISMS *Journal* show, moreover, that new research results, drugs, and procedures entered medical practice in the state, but it is impossible to know from these texts how many Iowa physicians actually studied these innovations and incorporated them successfully into their own work.¹⁰

Focusing on the professional preoccupations of members of the Iowa State Medical Society also requires acknowledging that the vast majority of them were white and male. The editors of the ISMS *Journal* occasionally noted when an African American doctor settled in Iowa, and in 1933 its "Interesting News" column noted that only eight African American physicians practiced in a state with 17,380 African Americans.¹¹ The health needs of African Americans, Native Americans, and other minorities generated no major articles or editorials, confirming the sense that those populations largely stayed below mainstream medicine's sightlines during the Depression and war years. Women's names appear as authors of articles in the ISMS *Journal*, but women never seem to turn up serving as county delegates to the business meetings of the society or participating in delegate discussions. Members were sometimes identified only by initials, so a few women may have played such roles, but certainly no woman was elected as an executive officer during these decades. Until 1942, some women physicians did gather each year for a day-long meeting of the "State Society of Iowa

10. For examples of reports of new drugs and therapies, see Elmer Kottke, "Non-specific Immunotransfusions in the Treatment of Hemolytic Streptococcus Septicemia," *JISMS* 24 (1934), 431-36 (on serum therapy); Frank G. Norbury, "The Use of Barbitol Products," *JISMS* 26 (1936), 338-43 (on barbituates, such as phenobarbital, sodium amytal, and nembutal); Arthur C. Christie, "Present Conception of Radiation in the Treatment of Cancer," *JISMS* 27 (1937), 1-9; R. B. Gibson, "Fluids for Intravenous and Subcutaneous Use," *JISMS* 29 (1939), 19-20; Elmer L. DeGowin, "Blood Transfusion Reactions," *JISMS* 29 (1939), 20-21; Ralph L. Gorrell, "The Uses of Benzadrine Sulfate in General Practice," *JISMS* 29 (1939), 451-53 (on amphetamines); James Green, "The Clinical Use of Adrenal Cortical Hormone," *JISMS* 30 (1940), 287-91; Capt. Harold Schwartz, "Analysis of the Rh Factor," *JISMS* 33 (1943), 217-19; and Diedrich J. Haines, "The Anticoagulant Drugs," *JISMS* 37 (1947), 446-49 (on coumadin and heparin).

11. "Personal Mention," *JISMS* 23 (1933), 173; "Interesting News," *JISMS* 23 (1933), 688. For an important survey of African American physicians in Iowa, see Steven Berry and Erin Herndon, "Healing Hands, Questing Hearts: African-American Physicians in Iowa," in Bill Silag et al., eds., *Outside In: African-American History in Iowa, 1838-2000* (Des Moines, 2001), 243-69.

Medical Women,” which held sessions on the day before the start of the ISMS regular annual conference. Between 1942 and 1950, however, the women had “no scientific programs” at their gatherings over lunch or dinner.¹² The absence of African American and women physicians in this article thus directly reflects their relative absence from professional power in the 1930s and 1940s, but not their absence from the practice of medicine.

Access to Care: Physicians, Hospitals, and Public Health

By 1928, the movement of physicians from rural areas to towns and cities was well under way. Telephones, automobiles, paved roads, hospitals, and the amenities of town life all played a part in this internal migration. Various experts debated the relationships among the number of doctors, their geographic distribution, and the adequacies of medical care for Americans, but Iowans certainly noticed that young physicians were not replacing small-town practitioners who moved or retired in the 1930s and 1940s.¹³ The 1940 federal census revealed, for example, that 67 percent of Iowa’s physicians lived in urban areas, while only 43 percent of the state’s population did.¹⁴ Less remarked upon in the state medical journal, but certainly noticeable in public data, were overall declines in the numbers of both physicians and hospitals between 1931 and 1950. There were 3,125 physicians practicing in Iowa in 1931 but only 2,890 in 1950. As the state’s population increased in those decades, the ratio of physician to residents dropped from one per 790 in 1930 to one per 907 in 1950 (see table 1). There was a perceptible drop in the number of general practitioners, as well, from 2,718 (87 percent) to 2,201 (76 percent), as more doctors chose to limit their work to a specialty. Similarly, the number of Iowa’s 99 counties that had a hospital fell from 75 in 1931 to 68 in 1950; the total num-

12. Jeannette Dean Throckmorton, “State Society of Iowa Medical Women,” in *One Hundred Years of Medicine in Iowa*, 425–26.

13. “The Rural Physician,” *JISMS* 26 (1936), 106; “Rural Medical Supply,” *JISMS* 37 (1947), 213–14.

14. U.S. Bureau of the Census, *Bulletin. Population. Third Series. The Labor Force* (Washington, DC, 1942), Table 10. In 1940 the Bureau of the Census defined “urban” as towns of more than 2,500 people.

TABLE 1
SPECIALTY PRACTICE IN IOWA, 1931 AND 1950

	1931	1950
Total number of physicians in Iowa	3,125	2,890
Number limiting practice to a specialty	407 (13%)	689 (24%)
Specialists with national board certification	31*	279**
General practitioners	2,718 (87%)	2,201 (76%)

SOURCE: *The American Medical Directory*, 1931 and 1950.

*In 1931 only three specialties had national boards: Ophthalmology (1917), Otolaryngology (1924), and Obstetrics and Gynecology (1930).

**In 1950, sixteen specialties had national boards: Ophthalmology (1917); Otolaryngology (1924); Obstetrics and Gynecology (1930); Dermatology (1932); Pediatrics (1933); Orthopedic Surgery (1934); Psychiatry and Neurology (1934); Radiology (1934); Urology (1935); Internal Medicine (1936); Pathology (1936); Anesthesiology (1937); Plastic Surgery (1937); Surgery (1937); Neurological Surgery (1940); Physical Medicine and Rehabilitation (1947).

ber of institutions fell from 175 to 133 across the state (see table 2). These were hardly dramatic changes, but they nevertheless suggest that some Iowans had reasons to believe that access to basic medical care had gotten worse, not better, in those years.¹⁵

A few bare numbers tell only part of the story, of course, and can have multiple interpretations. From the perspective of the profession's leaders, the decline in the number of doctors was a necessary corrective to the oversupply of poorly trained physicians pumped out of proprietary medical schools in the late nineteenth and early twentieth centuries. The drop in the number of hospitals in Iowa occurred because quite a few very small, privately owned hospitals closed in these decades. Some hospitals merged with others, especially in larger towns and cities, and yet other institutions added buildings and wings, so that there were actually more hospital beds in Iowa in 1950 than in 1931, even if they were farther away from small rural communities.¹⁶ Professional leaders thus also saw the end of small hospitals that, in some cases, were no more than boardinghouses with nursing care and a physician close by, as a sign of progress.

15. T. A. Moran, "Are Prospective Medical Students Getting a Square Deal?" *JISMS* 27 (1937), 500-501.

16. Iowa followed national trends in hospital closings and distribution. See Rosemary Stevens, *In Sickness and In Wealth: American Hospitals in the Twentieth Century* (New York, 1989), 121-22, 147-49.

TABLE 2
HOSPITALS IN IOWA, 1931 AND 1950

Primary funding and affiliation	1931	1950
Religious and charitable: Total	65	72
Catholic	29	32
Protestant	15	14
Charity/Non-profit Associations	19	26
Fraternal	2	
Private individual or partnership businesses: Total	75	30
Private – physician owned	54	22
Private – other groups and unknown	20	7
Railroad consortium	1	1
Tax-based institutions: Total	35	31
Federal – Military and Veterans	2	2
State – Mental disorders	6	7
State – General	2	2
State – Tuberculosis	2	1
County – Mental disorders	3	
County – General	5	4
County – Tuberculosis	4	3
County – Isolation		1
Municipal – General	8	11
Municipal – Isolation	3	
Total	175	133

SOURCES: Clyde A. Boice, "Hospitals in Iowa," in *One Hundred Years of Medicine in Iowa*, 371-419; *American Medical Directory*, vol. 12 (1931); "Hospitals Registered by the American Medical Association," *JAMA* 146 (1951), 139-40. The 1950 data include the Atchison, Topeka and Santa Fe Railway Employees Hospital in Fort Madison, as physicians listed it as their place of work in the *American Medical Directory*, 1950.

The American College of Surgeons (ACS), a national group heavily invested in improving the quality of hospital facilities for surgical work in these decades, had started reviewing and certifying hospitals that met their minimum standards for staffing, equipment, and services in 1918.¹⁷ Only 34 Iowa hospitals met their standards in 1931. The number went up to 46 by 1950, but that was still only 35 percent of the state's institutions.

17. Stevens, *In Sickness and In Wealth*, 68-70, 116-20. Samuel Levey et al., *The Rise of a University Teaching Hospital: A Leadership Perspective*, *The University of Iowa Hospitals and Clinics* (Chicago, 1996), 94-97, covers the introduction of ACS standards and the UI hospital's compliance; for residencies, see 181-83.

The shift toward fewer but better physicians and fewer but better hospitals played out well for the residents of Iowa's larger cities. The resulting geographical inequities, along with continuing debates over what access to health care really meant, nevertheless heightened the perception that rural populations were increasingly underserved. In the postwar years, Iowa legislators generally supported the push for federal funding to build hospitals and health centers for rural areas.¹⁸ Finding solutions for the unequal distribution of physicians, especially with the decline in the number of general practitioners, was far more contentious, and it has remained an ongoing political and economic issue.¹⁹

To the concern about the number and distribution of physicians, adequate hospitals, and rural versus urban practice must be added frictions between academic medicine—the medicine of research institutes, university medical schools, large teaching hospitals, and prestigious specialty boards—and the medicine of full-time community practitioners. Gown-and-town tensions were certainly not new to medicine in Iowa, but some became particularly sharp during the Depression and war, and played a role in medical politics throughout the state.

After 1913, the University of Iowa (UI) College of Medicine was the only regular medical school in Iowa, and Iowa's physicians were repeatedly urged to support and admire "their" college of medicine and the university's hospitals. That was not always easy when it seemed that the UI's need for resources conflicted with small-town practitioners' needs for payments and patients. The Perkins Act (1915) and the Haskell-Klaus Act (1919) funded a steady stream of indigent children and adults to the UI hospitals, where their numbers allowed for major expan-

18. "Rural Health Program in Iowa," *JISMS* 36 (1946), 527–28; "Hospital Construction in Iowa," *JISMS* 36 (1946), 494–95; "Hospital Survey and Construction Program," *JISMS* 39 (1949), 22–23. On the shortage of nurses and technicians for new hospitals, see "What Will the Hospital Building Program Entail?" *JISMS* 40 (1950), 187.

19. Lee Anderson, *Internal Medicine and the Structures of Modern Medical Science: The University of Iowa, 1870–1990* (Ames, 1996), 134–38; "National Conference on Medical Service," *JISMS* 37 (1947), 134; Arthur D. Woods, "General Practice and Licensure," *JISMS* 40 (1950), 199–204.

sion into the new Children's Hospital (1919) and General Hospital (1928). Those patients provided the population base for teaching cases, without which the medical school could not survive. Care of the indigent—and the distribution of the tax funds that supported that care—was a major source of envy and hard feelings in the 1930s and 1940s. On the other hand, the state's academic medical center administrators and faculty felt considerable frustration over budget cuts, calls to end or modify indigent care funding to the UI, and complaints from Iowa physicians that UI doctors competed unfairly with non-UI practitioners for private (paying) patients.²⁰

Much of the sense of unfair competition came from the obvious associations between the UI's medical school, its tax-supported teaching hospital, and the rise of specialty practice. Across the United States, specialization thrived in medical schools and teaching hospitals, and the UI was no exception. In 1928 the UI had 13 clinical departments, each with specialists as faculty. Together with faculty in the basic science departments, specialists parceled out lecture, laboratory, and clinical time in the four-year medical curriculum to piece together the education of the all-purpose doctor who, after one year of hospital experience as an intern, could jump into general practice.²¹ Many medical students did enter general practice, but the allure of specialization intensified in the 1930s and 1940s. Specialists topped the hierarchy in science-based medical knowledge, clinical expertise, and professional prestige, as students could not help but notice as they made hospital rounds. They also made a great deal more money than general practitioners. In 1931, for example, readers of the *ISMS Journal* learned that specialists in the United States averaged an income of \$16,000 per

20. W. W. Bowen, "The Present Status of Medicine," *JISMS* 24 (1934), 146. Lee Anderson's *Internal Medicine* provides a nuanced account of this troubled period from the UI College of Medicine's perspective; see especially 59–64, 80, 103–7. The UI hospitals' standpoint is equally well explained in Levey et al., *University Teaching Hospital*, especially 147–58, 188–95.

21. E. M. MacEwen, "Medicine and Medical Education in the Postwar Era," *JISMS* 35 (1945), 356–57; Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (New York, 1999), 66–70.

year, compared with an average of \$2,000 to \$5,000 for “well established [general] physicians in small communities.”²²

General practitioners could develop specialty interests by joining specialist medical societies, taking short courses in specialty areas, and announcing their shifts in practice to their colleagues and patients until they could restrict their work entirely to one field. As early as the late 1910s, however, national societies and organizations of specialists became increasingly concerned that any licensed physician could claim to be a specialist and limit his or her practice to a particular area of medicine, such as ophthalmology, obstetrics, or neurosurgery, without having to demonstrate appropriate knowledge and skills to her or his practicing peers. Instead of turning to state legislators for legal restrictions on what a self-proclaimed specialist could or could not do without an additional layer of licensing, specialists pushed for public recognition of voluntary certification of competence by professional boards, who represented national, not state or local, interests. From the American Board of Ophthalmology (1917) to the American Board of Physical Medicine and Rehabilitation (1947), representatives from a wide range of specialty societies met to establish the ground rules for their particular areas of expertise. As these national boards launched themselves, they all began with ways for existing practitioners to qualify for board certification through reputations achieved by publications, faculty positions, specialist society memberships, and the documentation of patients actually treated. For younger practitioners, and for future ones, each board set up expectations for years of clinical experience in the specialty and required applicants to pass national examinations of knowledge and skills. As the best way to gain appropriate clinical experience efficiently was through periods of hospital training beyond the internship year, specialty residency positions in hospitals became the standard route to specialty practice and, if desired, board certification.²³

Of course, not just any hospital would do for residency education. In 1920 the AMA's Council on Medical Education and

22. “Interesting News,” *JISMS* 21 (1931), 95.

23. Ludmerer, *Time to Heal*, 80-101; Starr, *Social Transformation*, 223-25, 356-57.

Hospitals started to identify hospitals that had the facilities and staff necessary to offer internship training, and the council extended its purview to approve hospitals for residency positions in 1924. The number of hospitals in Iowa that could offer the internship experience required for medical licensing stood at ten in 1931, 1940, and 1950, all—except for the hospitals in Iowa City—in cities with more than 40,000 residents: Cedar Rapids, Council Bluffs, Davenport, Des Moines, and Sioux City. Even more was expected for hospitals to qualify for residency positions, because such training created the profession's elite. In Iowa in 1931 only two hospitals had residencies: UI's general hospital and the UI Psychopathic Hospital, which provided specialty training in psychiatry. To these, by 1940, were added Oakdale Sanatorium for specialists in lung diseases and St. Luke's Methodist Hospital in Cedar Rapids. By 1950, the total number had increased to ten hospitals, including several general hospitals in Des Moines and, for psychiatric specialization, the Cherokee State Hospital for Mental Diseases in Cherokee.²⁴ Five hospitals had both internship and residency approval in 1950.

The distribution of hospitals approved for internships and residencies reflected the distribution of Iowa physicians who not only claimed specialty practice, but also achieved board certification. For the state as a whole, 279 (40 percent) of the 689 specialists had passed national board requirements by 1950 (see table 1). At the UI Hospital, 90 percent of the 61 faculty who were specialists in areas with national boards had qualified for them. In Des Moines, the largest urban area in Iowa (and ten times the size of Iowa City), 51 percent of the 118 who limited their practices to a specialty with a national board had a board certification. In contrast, of the five small cities in Iowa with populations between 10,000 and 15,000, only 18 of the 91 physicians (20 percent) restricted their work to a board-recognized specialty, and just five of them (28 percent) had sought board certification by 1950.²⁵

24. Entries for hospitals in Iowa in the *American Medical Directory*, 1930 and 1939; "Hospitals Registered by the American Medical Association," *Journal of the American Medical Association* (hereafter cited as *JAMA*) 146 (1951), 139–40.

25. *American Medical Directory*, 1950. The five small cities were Ames, Boone, Fort Madison, Newton, and Oskaloosa. Only the last three had general hospi-

The UI Hospital clearly did not have a monopoly on specialists, even board-certified specialists, but it did have the high ground when it came to expecting that clinicians would obtain the official approbation of national peers when claiming expertise in specialty areas. The fear that UI specialists would—and did—draw well-to-do private patients from across the state, away from perfectly fine practitioners in other cities and towns, led to an understanding reached in 1928 that no more than 5 percent of the beds in the UI hospitals could be used for paying patients. This minimum was regularly overlooked, however, which fueled Iowa physicians' anxieties in these decades, especially when a few outspoken UI clinicians roundly criticized any restriction on their private practices. Whether the UI faculty could realistically have threatened many physicians' livelihoods matters less than the way that the UI stood for all of the changes affecting medicine: larger and larger hospitals with fancy diagnostic laboratories, the newest in expensive, advanced devices (such as the first respirator and electrocardiograph), increasing expertise in highly technical research science, and the fragmentation of the patient into dehumanized parts.²⁶

Private practice physicians across the state also dealt with the mixed blessings of state-funded public health programs, regulations, and initiatives in the decades from 1928 to 1950. On the one hand, public health work to improve sanitation, gather vital statistics, monitor outbreaks of infectious diseases, promote vaccinations, and educate Iowans about personal hygiene all had visible results, despite the privations of the Depression and war. Maternal and infant mortality declined substantially during these years (see fig. 1). By 1946–47, Iowa

tals, although there was an infirmary at Iowa State University for students that may have been available in emergencies to other Ames residents. Medical sociologists have studied the distribution of physicians in considerable depth, using sophisticated statistical methods. See, for example, David L. Brown, "The Redistribution of Physicians and Dentists in Incorporated Places of the Upper Midwest, 1950–1970," *Rural Sociology* 39 (1974), 205–23.

26. Anderson, *Internal Medicine*, 104–6; Levey et al., *University Teaching Hospital*, 188, 192–95, 234–39; "Report of Committee on Medical Education and Hospitals," *JISMS* 40 (1950), 342–44; "The Family Doctor and the Specialist," *JISMS* 21 (1931), 189; "A New Therapeutic Problem," *JISMS* 29 (1939), 462; "The Role of the General Practitioner," *JISMS* (1947), 171–72.

FIGURE 1
DEATH RATES IN IOWA, 1925-1950:
TOTAL DEATHS, INFANT DEATHS, AND MATERNAL DEATHS



SOURCE: Division of Records and Statistics, Iowa State Department of Health, *Vital Statistics of Iowa* (Des Moines, 1977), Table 3.

boasted the lowest death rate from tuberculosis in the nation: 11.8 per 100,000 people, compared with the national rate of 33.5 per 100,000.²⁷ These successes came primarily from traditional public health techniques that focused on identifying individuals with diseases, urging those who needed professional care to seek it, and imposing quarantines or isolation on actively contagious citizens.²⁸ Antibiotics, notably streptomycin (developed in 1944-1946), effective against tuberculosis, and penicillin (from laboratory work to mass production between 1938 and 1943),

27. "Iowa Leads in Tuberculosis Program," *JISMS* 36 (1946), 298-99; "Tuberculosis Death Rate per 100,000 Population among Residents of Each State," *JISMS* 39 (1949), 216. For a comparison with earlier data, see "Tuberculosis Morbidity and Mortality in Iowa," *JISMS* 25 (1935), 617-18.

28. For an overview of public health developments in the United States in these decades, see John Duffy, *The Sanitarians: A History of American Public Health* (Chicago, 1990), 256-72. For discussions of the demographic transition from deaths due to infectious diseases to deaths from chronic conditions such as heart disease and cancer, see the still classic Thomas McKeown, *The Modern Rise of Population* (New York, 1976); and James C. Riley, *Rising Life Expectancy: A Global History* (Cambridge, 2001).

the wonder-drug for a range of infections that affected maternal and infant morbidity, did not have a significant impact until they reached mass distribution and physicians learned how and when to administer them.²⁹

Iowans were a bit more reluctant to embrace vaccination against smallpox, however, which led Walter Bierring, the State Commissioner of Health from 1933 through 1953, to observe in 1942 that Iowa had an "undesirable reputation of being one of the hotbeds of smallpox infestation in the nation."³⁰ Physicians were required to immediately report cases of major infectious Diseases to the State Department of Health so that nascent epidemics could be contained, and Dr. Bierring issued monthly reports and warnings, published in the *ISMS Journal*, listing numbers of cases and, except for syphilis and gonorrhoea, the counties where cases appeared.³¹ Both physicians and public health workers knew well, however, that doctors were not always called even for serious diseases, such as smallpox, measles, and diphtheria, which allowed them to spread and, of course, skewed the numbers that Dr. Bierring's department so carefully

29. John E. Lesch, "The Discovery of M & B 693 (Sulfapyridine)," in *The Inside Story of Medicines: A Symposium*, ed. Gregory J. Higby and Elaine C. Stroud (Madison, WI, 1997), 101-19; "Let's Be Getting Ready for Penicillin," *JISMS* 33 (1943), 475-76; J. Donald Anderson and Lee Forrest Hill, "Penicillin in the Treatment of Severe Staphylococccic Bacteriemia with Complications: Report of a Case," *JISMS* 34 (1944), 191-98; Karl H. Pfueteze and Marjorie M. Pyle, "Uses and Limitations of Streptomycin in Tuberculosis," *JISMS* 38 (1948), 467-71. Harry F. Dowling, *Fighting Infection: Conquests of the Twentieth Century* (Cambridge, MA, 1977), 126-32, 179-82, discusses the discovery of antibiotics, and, on pp. 48-49 and 106-16, earlier treatment of infections, especially the use of serum treatments and sulfonamides.

30. "Fourth Annual Immunization Campaign," *JISMS* 32 (1942), 462; "1948 Our First Year Without Smallpox," *JISMS* 39 (1949), 72. Resistance to vaccination for smallpox in the late 1930s and 1940s in Iowa, and elsewhere in the Midwest, requires more research. Existing historical accounts suggest that the anti-vaccination movement had more or less disintegrated by the 1930s, but this seems to underplay continuing localized fears of the procedure. See Martin Kaufman, "The American Anti-Vaccinationists and their Arguments," *Bulletin of the History of Medicine* 41 (1967), 463-78.

31. For mandatory reporting laws, state authority to require quarantines, placarding, and, if necessary, forcible removal to isolation wards or hospitals for those seen as a danger to public health, see 1931 *Code of Iowa*, ch. 108. For an overview of the centralization of public health administration to 1933, see N. W. McGee, "State Administration of Public Health in Iowa," *Iowa Journal of History and Politics* 31 (1933), 163-210.

tabulated each month.³² Public health surveillance and notifications also alerted Iowa's physicians to diseases that had been under-appreciated or even barely recognized as health threats at the start of the twentieth century, such as poliomyelitis and undulant fever (later renamed brucellosis).³³ Even before combat in the Pacific brought U.S. soldiers back home to Iowa with worrisome—and infectious—tropical diseases, moreover, Dr. Bierring alerted the state's doctors to a rise in reported cases of malaria, a debilitating and sometimes fatal disease carried by anopheline mosquitoes.³⁴ The persistence of smallpox, outbreaks of polio, and a potential postwar resurgence in malaria reminded Iowans not to become complacent just because typhoid, diphtheria and tuberculosis seemed to be on the wane.

On the other hand, physicians remained concerned that public health initiatives, especially when championed by lay groups, would trespass upon the individual, fee-for-service practice of medicine. Dr. R. G. Leland of Chicago assured members of the ISMS in 1934 that "you do not here have the same fears, the same encroachments of health department activities on the practice of medicine, that exists in some other states," and he praised Dr. Bierring's intent to keep proper boundaries around public health measures. Major efforts to improve children's health by organizing annual "round-ups" of schoolchildren for medical checkups, for example, required careful negotiations among the staff of the Bureau of Maternity and Child Hygiene (part of the

32. See, for example, "The Lost Sheep," *JISMS* 25 (1935), 98–99.

33. Wade H. Frost, "The Epidemiology of Poliomyelitis," *JISMS* 19 (1929), 223–28; "The Death Rate in Iowa Increases," *JISMS* 21 (1931), 520; "Sulfanilamide and Sulfapyridine in Polio," *JISMS* 29 (1939), 462–63; "Unprecedented Incidence of Poliomyelitis," *JISMS* 30 (1940), 491–92; Joe M. Standerfer, "Acute Poliomyelitis: A Study of the Patients Seen at the Raymond Blank Memorial Hospital During 1946," *JISMS* 37 (1947), 362–66; A. V. Hardy, "Undulant (Malta) Fever in Iowa," *JISMS* 19 (1929), 483–84; Carl F. Jordon, "Problems in the Control of Undulant Fever," *JISMS* 20 (1930) 507–10; L. R. Woodward, "Brucellosis," *JISMS* 27 (1937), 609–14.

34. "Occurrence of Malaria in Iowa," *JISMS* 25 (1935), 558, 570; E. E. Munger and E. E. Munger Jr., "A Case of Malaria," *JISMS* 27 (1937), 209–10; Walter Bierring, "Malaria in the Upper Mississippi Valley," *JISMS* 30 (1940), 294–95; James E. Greene, "Tropical Diseases in Iowa in the Postwar Era," *JISMS* 33 (1943), 455–60; Col. Paul F. Russell, "Malaria in Returning Service Personnel," *JISMS* 35 (1945), 247–53; Edward W. Paulus, "Malaria as a Postwar Problem in Iowa," *JISMS* 37 (1947), 12–17.

State Department of Health), representatives from parent and teacher associations, and members of county medical societies to ensure that any information distributed was physician-approved and that doctors who participated were appropriately compensated. Physicians involved in running private laboratories in 1934 protested strongly when the State Department of Health planned to maintain its "free" (tax-funded) clinical laboratory services for testing blood, spinal fluid, and tissues for infectious diseases, agreeing only that the state hygienic laboratory should provide free tests for indigent patients. Otherwise, they maintained, individuals should be charged the same fees expected from private laboratories. In 1950 the ISMS Board of Trustees voiced its concern that the State Department of Health had agreed to give the Iowa Heart Association "\$10,000 and a truck with x-ray" for the "diagnosis and treatment of heart conditions." Diagnostic screening of "indigent or semi-indigent persons" was in line with past initiatives, but "with the treatment part being left to the private practice of medicine." The board called for the ISMS to again scrutinize such well-meaning but ill-advised plans that wandered over the fuzzy border separating public health from private medical care.³⁵

For physicians in the ISMS, a central goal running through all of the economic, social, scientific, and international upheavals of the 1930s and 1940s was to remain, as Dr. Fay said, "unshackled by bureaucratic control" while the profession and the practice of medicine was changing all around them. Yet, despite the bravado of several outspoken leaders, there were just too many factors that independent, individualistic physicians could not control on their own. To resist "outside" dictates, they had to face head on the increasingly unpleasant conflicts among idealized professional altruism, providing the best in up-to-date science-based diagnostic tests and treatments, and the financial bottom line: people who needed medical care could not, or would not, pay their bills.

35. R. G. Leland, "Some Causes of Professional Unrest," *JISMS* 24 (1934), 603; "Report of Committee on Child Health and Protection," *JISMS* 23 (1933), 422; "The 1941 Summer Round-Up," *JISMS* 31 (1941), 167; "Report of the Medical Economics Committee," *JISMS* 25 (1935), 405-7; "Supplemental Report of the Board of Trustees," *JISMS* 40 (1950), 331.

Medical Care and Poverty before the New Deal

Ralph Simmons, editor of the *ISMS Journal*, welcomed 1931 with an optimistic editorial, looking back on 1930 as a year “marked by prosperity and much personal happiness” in the Midwest, despite some “economic stress.” Economic stress continued, however, and Iowa physicians began to feel it keenly. At the annual meeting of the ISMS in April, Dr. Hearst reported to the society’s House of Delegates on the activities of the recently formed Committee on Indigent Physicians. Only a few poverty-stricken physicians had been identified, he said, but “it has been intimated that if the bulls don’t get busy in the stock market there will be more of this class.” A year later Dr. Hearst told the delegates that no one had yet reported any indigent physicians requiring assistance from the state society. “The various county societies had taken care” of needy colleagues, he noted. In 1933, however, requests for aid had come in from three practitioners. Dr. Ambor, then chair of the committee, found one “to require emergency action.” The ISMS Board of Trustees authorized a temporary payment of \$25 per month from the society’s reserve funds for this “truly needy physician.” Critical members of the society’s House of Delegates, discovering that the decision violated the society’s bylaws, challenged Dr. Ambor at the annual ISMS meeting in 1934. Dr. Fay, for example, asked the House, “Are you going into the insurance game and take care of these people?” “Who is going to determine whether they are indigent or whether they are not?” The House finally voted to disband the committee and abandon any formal ISMS help for indigent practitioners. Impoverished physicians, like so many others who just could not manage as conditions worsened in towns and on farms across the state, would have to rely on their neighbors, charity, and public aid to get by.³⁶

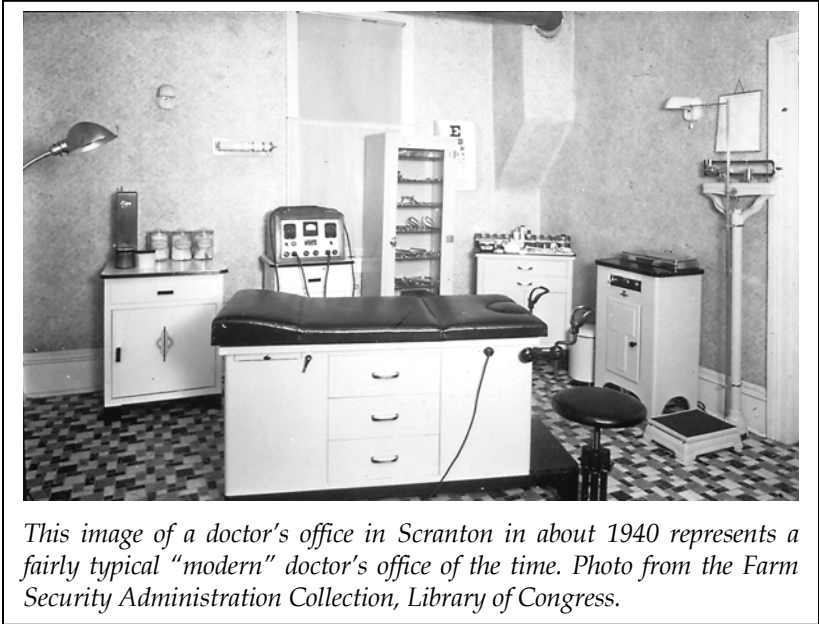
36. “A New Year’s Reflection,” *JISMS* 21 (1931), 32; “Report of Committee on Indigent Physicians,” *JISMS* 21 (1931), 400; “Physicians become Chauffeurs,” *JISMS* 22 (1932), 550; “Report of the Committee on Superannuated Physicians,” *JISMS* 22 (1932), 363; “Report of the Committee on Superannuated Physicians,” *JISMS* 24 (1934), 391, 394. Appeals to the AMA to set up a national benevolent fund for impoverished physicians were finally answered when the Bureau of Medical Economics decided that the AMA could not get into “the insurance business.” “Report of the Delegates to the American Medical Association,” *JISMS* 28 (1938), 324.

Between 1929 and 1932, the national average net income for physicians in independent private practice dropped almost 44 percent, from \$5,224 per year to \$2,948. After 1932, however, the average gradually rose again until, in 1943, the mean income after business expenses reached \$6,735.³⁷ Most Iowa physicians managed to make do through the leanest years in areas not affected too keenly by the ongoing droughts. According to a survey that the ISMS *Journal* sent out to members in 1935, just under two-thirds of Iowa physicians owned one car (“a Ford or a Chevrolet”), which was two or more years old; the rest owned two cars. Seventy-five percent owned electric refrigerators, 40 percent were planning home improvements, and most had kept up payments on their life insurance policies. The author of the report on this questionnaire regretted that it had not gathered reliable information on the average Iowa physician’s income, as, “alas, his earnings and his collections are so widely different that it is too uncertain to estimate.”³⁸

The difference between earnings on paper, tallied according to fees charged, and what a physician actually collected in cash (or kind) had burdened practitioners for hundreds of years. Nineteenth- and early twentieth-century physicians were no strangers to poverty or marginal incomes when they could not attract enough well-to-do patients who paid their bills promptly and fully. Physicians regularly extended personal credit to their patients and arranged payment schedules that could keep their clientele in debt to them for years. In the 1920s and 1930s, however, the cost of being a physician and running an independent practice had risen dramatically with the reform of medical education and the introduction of expensive equipment for the doc-

37. William Weinfield, “Income of Physicians, 1929–49,” *Survey of Current Business* 31 (1951), 10–11. Data presented in the AMA’s *Care of the Indigent Sick*, rev. ed. (Chicago, 1935), 28, indicate that in 1929 an income of \$5,500 for a family of three put them in the “well-to-do” category. In 1934 the minimum income for a family of five for basic needs, including a telephone and some recreation, was \$1,921. There are several ways to calculate the “value” of money in the past in current terms. The results can vary widely depending upon the factors considered meaningful to the economist and historian. To try such calculations on the dollar amounts given in this article, consult MeasuringWorth.com <www.measuringworth.com/calculators/compare>, accessed 2/16/2007.

38. “An Average Iowa Physician,” *JISMS* 25 (1935), 559–60. The survey was sent to all ISMS members; approximately 50 percent responded.



tor's office. Keeping up with the latest developments, moreover, required society dues, journal subscriptions, and, most of all, travel to medical meetings, postgraduate courses, and refresher clinics. Juggling expenses and income in these decades meant that the physician had to learn to be a sound businessperson. As one Iowa practitioner put it in 1933, "We have not yet learned to cause our fees to collect in pens about our home so that when they are needed we know that they are in the pen ready for us." Instead, like hunting wild game, ordinary doctors had to stalk their fees—a laborious and inefficient task. By the mid-1920s, some collection agencies specialized in getting payments from patients for a percentage of the bills owed. Physicians turned to such agencies when they simply could not afford to write off all of their bad debts, but this must have been an uncomfortable process in close-knit communities.³⁹

39. W. L. Allen, "Our Profession Needs to Revolutionize its Business Methods," *Iowa Medical Journal* 15 (1908-1909), 394-97; Ezra L. Wurtzer, "Medical Economics," *JISMS* 21 (1931), 341-43; G. Hubert Artis, letter to "The Open Forum," *JISMS* 23 (1933), 526; "Commercial Collection Agencies," in the "Report of Committee on Medical Economics," *JISMS* 21 (1931), 392-93; [Letter to the editor from E. Burd; Editor's reply], *JISMS* 16 (1926), 509-10.

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The "National School of Honesty" advertised regularly in the Journal of the Iowa State Medical Society in the 1930s and 1940s. This ad appeared in March 1935.

Physicians' problems with fees and payments also stemmed from another long-standing tradition in medical practice: the sliding scale and physicians' personal generosity with their time. It was well known that physicians charged their poorer patients less for the same services than they charged those with adequate means, and that sometimes they charged nothing at all. By the late 1920s, the individual physician's freedom to use a sliding scale and extend credit had created considerable dissension in the profession. On one hand, physicians prized their flexibility with payment as part of their autonomy as practitioners and as a fundamental expression of the altruism of medicine itself. Independence in caring for those in need according to their own clinical judgments without regard for personal gain was a deeply held value, intertwined with feelings about self-respect and community regard. Practitioners feared that talk of business efficiency and payment demands threatened their patients' trust in them and stimulated public opinion that doctors were arrogant and money-grubbing. On the other hand, the variation in physicians' fees had long been seen as fueling competition among practitioners and encouraging quackery, contract practice, incompetent medical care, and bitter divisiveness in the profession. The very altruism that gave physicians pride, more-

over, "gives the layman a chance to play us for 'suckers,' if he so chooses," Dr. Wurtzer of Clear Lake noted in 1931. "Some of the disrespect and disregard that some of the people have for the medical profession," Dr. Wurtzer continued, "is due . . . in part to our slothful methods of business dealings with the public."⁴⁰

Concern over physicians' billing autonomy versus the collective good of the profession was one of the issues motivating the formation of medical societies, including the American Medical Association, in the nineteenth century. Some city and county medical societies occasionally put together suggested fee schedules suitable for their areas, but prosperous practitioners and specialists complained that "suggested" fees too quickly became "maximum" fees and that "cheap doctors" were always willing to undercut respectable ones.⁴¹

Society-based fee schedules as a partial solution to the wide variation in medical charges also became problematic with the passage of workers' compensation laws in the first decades of the twentieth century. Iowa's law passed in 1913 and went into effect on July 1, 1914.⁴² Such laws required that employers pay for the medical care and time off required when an industrial worker was injured on the job and it was not the worker's fault. (The law did not apply to farm labor, nor did it include work-related diseases.) To fund this responsibility, Iowa employers established a private insurance association (the Employers Mutual Casualty Association of Iowa), which entered into contracts with physicians around the state to provide medical services as the need arose, with a legislated limit of \$100 for medical costs per injury. The insurance association determined which physi-

40. J. N. McCormack, "Medical Economics—A General Plan for a Schedule of Medical Fees," *Iowa Medical Journal* 15 (1908–1909), 393; Ben G. Budge, "Honesty in Medicine," *JISMS* 21 (1931), 482–84; "The Business of Medicine," *JISMS* 17 (1927), 137; Ezra L. Wurtzer, "Medical Economics," *JISMS* 21 (1931), 341–43; "Physicians and Fees," *JISMS* 23 (1933), 625; Cleon C. Mason, "The Business of Doctoring," *North American Review* 226 (1928), 737–42. See also T. Swann Harding, "The High Cost of Doctoring," *North American Review* 226 (1928), 390–98.

41. McCormack, "Medical Economics," 390–91.

42. "Employer's Liability or Workmen's Compensation," *JISMS* 3 (1913–14), 762–66; "Accident Insurance," *JISMS* 3 (1913–1914), 769–75. For a general discussion of workers' compensation legislation, see Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, MA, 1992); and Hoffman, *Wages of Sickness*.

cian took care of an injured employee and, with the contract system, also determined the fees. The association argued that since physicians would be assured of prompt payment, they should be happy with half their normal charge—indeed, what they might have expected a worker to be able to pay anyway. Fee schedules generated by county medical societies provided evidence that insurance companies used to establish the customary charges that they could discount.⁴³

Physicians' responses to workers' compensation in Iowa heralded later reactions to legislative solutions to managing health care and medical practice. Some were horrified and adamantly denounced all forms of contract practice, but offered few ideas about what should be done about it or about workers' compensation laws. Others counseled cooperation with the state and insurance companies, as interference with medical costs was inevitable, given all the political discussion about European systems of state medicine for industrial workers and the popular lure of "free" health care. Still others urged action and physician solidarity. The physicians of Poweshiek County, for example, banded together in 1916 and refused to sign any contracts with the Employers Mutual Casualty Association. Those who handled casualty cases in the county were "getting decent, respectable fees for their work" as a result of their unified resistance. Getting all local physicians to cooperate, however, was a daunting task. Contract practice did offer some payment security, after all. It allowed "young men to obtain a start" in business and, of course, provided an income to those who could not get patients any other way. Insurance companies, observed Dr. Wahrer of Fort Madison in 1915, "know they can find a taker" in contrast to "butchers, grocers, brick layers, carpenters, farm-

43. D. S. Fairchild, "The Effects of the Workmen's Compensation Law on the Profession," *JISMS* 6 (1916), 161; "Report of the Committee on Workmen's Compensation," *JISMS* 7 (1917), 284; Oliver J. Fay, "The Relation of the Doctor to the Iowa Workmen's Compensation Service," *JISMS* 9 (1919), 120-21, 124-25. By the early 1930s, the ISMS's Committee on Medical Economics had the task of negotiating a recommended statewide minimum fee schedule for all compensation cases. See "Report of the Committee on Medical Economics," *JISMS* 23 (1933), 414-16. For details on the management of workers' compensation in specific cases in Iowa, see A. B. Funk, "Report of Decisions by the Department and State Courts," in State of Iowa, Report of Workmen's Compensation Service, 1930, *Legislative Documents*, vol. 3.

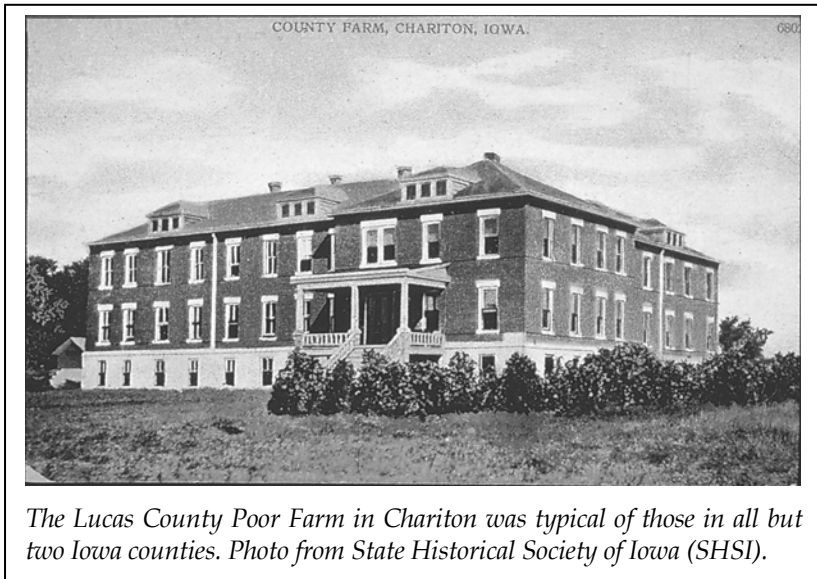
ers, char-women, scavengers or motormen," who, he implied, had more sense. "Above everything else," Dr. Schilling urged, "the doctor should maintain his self-respect, and when one of these contracts is presented to him and it involves the degradation of his profession, he should refuse to sign it."⁴⁴

Smoldering alongside resentment of workers' compensation contract practice was similar animosity toward contract practice for the care of the indigent sick in Iowa's counties. By state law every county was responsible for supporting indigent residents with the minimal necessities of life, including basic medical treatment, paid for by county taxes and managed by the county's board of supervisors.⁴⁵ In 1928 all but two of Iowa's counties had a poor farm, where those with no other options were sent. Such residential facilities were considered the most cost-effective way of feeding and sheltering the homeless indigent, along with the aged and disabled whose families (if they had family) did not have enough resources to care for them. The able-bodied on the farms labored with stock and crops, but sales of their produce rarely covered the expenses for maintaining the property, providing clothing and food for the inmates, and paying for medicine and doctors' visits.⁴⁶ Counties also used "outdoor" relief, that is, payments for those who still had their own homes but no means of support, such as women with dependent children. In addition, counties had to pay for the

44. "The Doctor's Economic Relationship," *JISMS* 10 (1920), 123-26; Donald L. Madison, "Preserving Individualism in the Organizational Society: 'Cooperation' and American Medical Practice, 1900-1920," *Bulletin of the History of Medicine* 70 (1996), 442-83; Fairchild, "Effects of the Workmen's Compensation Law," 158-63; Clinton E. Harris, "Co-operation: What does it Mean?" *JISMS* 6 (1916), 10, 163.

45. Marilyn Olson, "Sick and Poor in Cedar County: Local Government and the Poorhouse, 1857-1890," unpublished paper presented at the Newberry Library Seminar in Rural History, 2/24/2007. Olson provides important data on how a county government dealt with paying physicians for the care of the poor in the nineteenth century.

46. *Report of the Auditor of State for the Biennial Period Ending June 30, 1930* (Des Moines, 1930). Tables 12 and 13 give county home expenses and income from the sale of produce for 1928, for example. In 1928, 97 of Iowa's 99 counties had poor farms, with 2,425 poor and 1,459 insane inmates; one county had a farm where indigents worked, but the building for the residents had been condemned. Costs for medicine and medical attendance for county home residents totaled \$29,247, or 2.2 percent of the \$1,310,183 expended.



The Lucas County Poor Farm in Chariton was typical of those in all but two Iowa counties. Photo from State Historical Society of Iowa (SHSI).

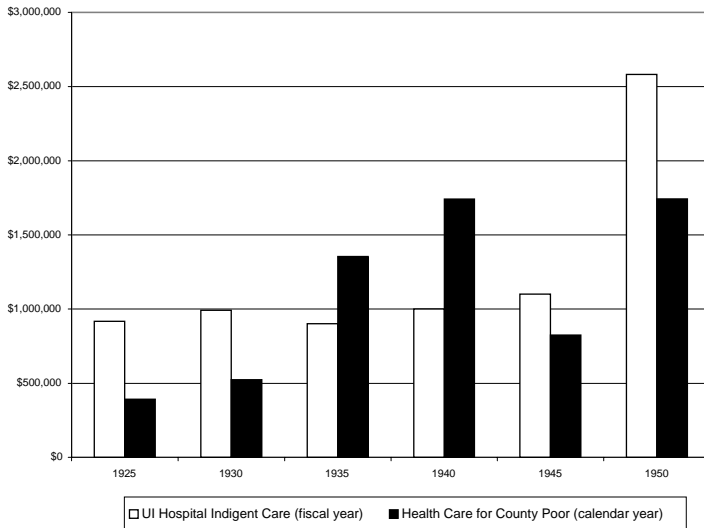
cost of resident indigents confined in one of the state hospitals for the insane. The voters of each county decided on the tax rate for poor relief. Most counties were reasonably generous, levying more for the poor than for county road building in 1928, for instance, but others were decidedly parsimonious.⁴⁷

When faced with seriously ill indigent children and adults, county authorities could send them to the UI hospital, where their medical costs would be covered by state funds under the Perkins Law and the Haskell-Klaus Law, up to a mandated cap of one million dollars per year.⁴⁸ In the late 1920s and early 1930s, problems with the ways some counties used more than their fair share of Perkins-Haskell-Klaus support, concern that patients who could be treated locally—with local physicians and hospitals deserving the income—were being sent away unnecessarily, rumors that some patients were not really indigent, and the start of long waiting lists for beds in Iowa City led to in-

47. State Board of Assessment and Review, *Taxable Valuation of Property* (Des Moines, 1929). Table 2, Part IV breaks down all taxes levied for 1928. The mills assessed for the poor ranged from the unusually low .55 for Osceola County to a high of 3.01 for Van Buren; the majority of counties assessed 3.00 mills for poor relief.

48. Lawrence, "Iowa Physicians," part two, 24, 43.

FIGURE 2
 TAX-FUNDED HEALTH CARE FOR THE INDIGENT IN IOWA:
 UI HOSPITALS (PERKINS & HASKELL-KLAUS) ALLOCATION
 COMPARED WITH TOTAL COUNTY EXPENDITURES

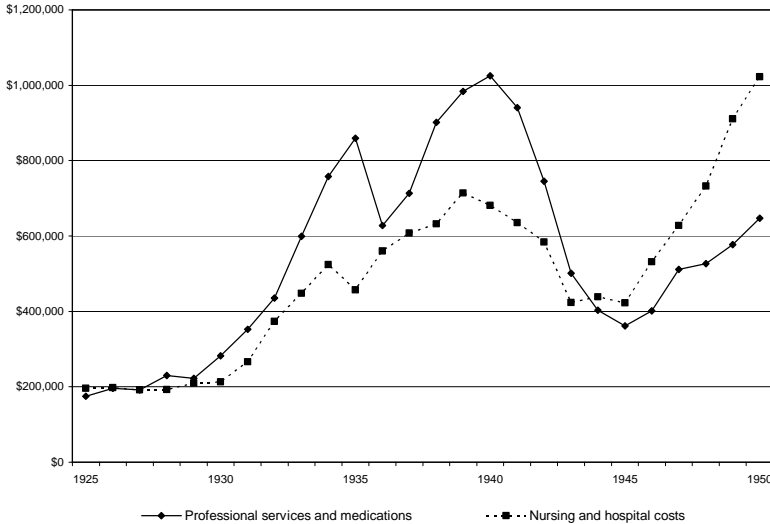


SOURCES: Compiled from State of Iowa, Report of the Auditor of State, for biennial periods ending in even years, 1926–1950. The health care costs for the county poor include physicians' fees, hospital and nursing charges, and drug costs for poor farm residents and those on outdoor relief.

vestigations by the state legislature and the ISMS. Negotiations among university administrators, medical society leaders, and state legislators led to reforms in the committal procedures to prevent abuses, but the cap in funding to the university hospital during the Depression meant that counties could not rely on the state's hospitals to relieve them of all the costs of their sickest poor (see fig. 2).⁴⁹ As the state's auditors' reports reveal, local ex-

49. Levey et al., *University Teaching Hospital*, 146–65, covers this controversy in detail from the University Hospital's perspective. This account does not discuss county-level work for the medical needs of the indigent. See also "Report of the Committee on Medical Economics," *JISMS* 21 (1931), 393; "Iowa Assembly Investigates University Hospital," *JISMS* 23 (1933), 221–25; "Supplementary Report of the Committee on Medical Education and Hospitals," *JISMS* 23 (1933), 400–404; Bowen, "The Present Status of Medicine," 146; Gordon F. Harkness, "The President Elect's Address: Why Are We Here and Where Are We Going?" *JISMS* 24 (1934), 274–77.

FIGURE 3

EXPENDITURES ON MEDICAL CARE BY IOWA COUNTIES, 1925-1950,
FOR THE POOR OUTSIDE OF POOR FARMS/COUNTY HOMES

SOURCE: Compiled from State of Iowa, Report of the Auditor of State, for biennial periods ending in even years, 1926-1950. Professional services include fees for physicians and dentists. These figures do not include amounts indirectly paid for medical services through FERA or FSA programs.

penditures on health care climbed significantly in this period, just as payments for fuel, food, and clothing for the poor also rose (see fig. 3).

Most county boards tried to budget a fixed amount for local indigent medical costs and, physicians constantly complained, tried to pay as little as possible for them. One popular method from the 1870s through the 1930s was to ask local physicians to submit sealed bids for an annual contract for services to the indigent and to accept the lowest one. Other county boards simply paid whatever fraction of the bills that physicians submitted that the boards thought the care was worth, which was nearly always 50 percent or less.⁵⁰ The AMA and the ISMS officially de-

50. Olson, "Sick and Poor in Cedar County;" Harris, "Co-operation: What Does It Mean?" 10; AMA, *Care of the Indigent Sick*, 33-36.

plored contract practice for indigent care, with one notable exception: when all of the physicians in a county medical society joined together to bid, as a group, for the contract. If voluntarily taken on by organized medicine, a contract that excluded physicians who did *not* belong to the AMA was considered professionally acceptable, as long as all AMA-affiliated physicians could participate. Because this unusual idea was dreamed up in Iowa, such a collective contract became nationally known as the “Iowa Plan” by the early 1930s.⁵¹

The physicians of the Black Hawk County Medical Society tried this collective initiative in 1907, well before the hard times of the Depression.⁵² In that year, they voted “to go before the county board of supervisors at the April meeting, and to underbid anyone who put in a bid to do the county poor work.” The supervisors agreed to their proposal, and the medical society got the contract for \$830 per year. Within a few years, “the physicians of Cedar Falls and Hudson preferred to make their own arrangements to care for the poor in their respective townships,” and the Waterloo Medical Society also decided that working at the city and township level made the most sense in Black Hawk County. In 1912 the Waterloo Medical Society decided to incorporate as a non-profit organization in order to reduce the personal financial responsibility of the society’s officers, and, by 1916, had used the contract funds for a variety of projects useful

51. Leland, “Some Causes of Professional Unrest,” 604. The use of the phrase “Iowa Plan” by physicians may easily be confused with the “Iowa Plan” developed by the Bureau of Social Welfare in the Extension Division of the State University of Iowa to have professional social workers coordinate all public and private relief efforts at the city or county level. See Bessie McClenahan, *The Iowa Plan for the Combination of Public and Private Relief* (Iowa City, 1918); Louise Cottrell, *Iowa Plan for the Organization of a County Social Service League* (Iowa City, 1924), and Ina Tyler, comp., *The Iowa Plan for the County Organization of Social Work* (Iowa City, 1931). There may well be connections between these “Iowa Plans,” but physicians do not acknowledge them in the articles cited here.

52. According to data provided by Robert A. Parker in “Care of the Indigent Sick by Medical Society Contract,” *JISMS* 21 (1931), 17, the Hardin County Medical Society started its collective contract arrangement in 1904. This has not yet been confirmed in the county’s board of supervisors records. This earlier venture was not mentioned in the first accounts about county medical society contracts published in the *JISMS* cited below.

for society members and the community. They set up x-ray services in two Waterloo hospitals and equipped a clinical laboratory in town, for example, which were supposed to eventually generate enough fees to be self-supporting.⁵³

Only 11 local medical societies had county contracts in 1930 (see table 3), but by 1933, 30 local medical societies had taken on the responsibility for local indigent care, based on an annual fixed sum or on a negotiated percentage of the minimum fee schedule devised by the ISMS that year.⁵⁴ In a decided show of communal good will, moreover, before 1933 most of the societies put some or all of the county contract funds into the society's treasury, where it was used to cover members' dues to the ISMS. The societies spent the remaining money on expenses for their meetings, particularly to bring in outside speakers for their programs.⁵⁵ The Jefferson County Medical Society even used this income to pay its members' premiums for group malpractice insurance, a nice inducement for non-members to join up.⁵⁶

Dr. Parker of Des Moines, reporting on the 11 medical society county contracts operating in 1930, stressed how much this collective use of contract funds helped in "the advancement of organized medicine," as it enhanced "the unity and fellowship among the members." Most reports from the county medical societies presented at the annual meetings of the ISMS in the early 1930s confirmed Dr. Parker's rosy assessment, although a few were less cheerful. Dr. Stirlen bluntly stated in 1934 that raising the idea to seek a county contract in 1933 "was the beginning of

53. W. B. Small, "President's Address—Iowa State Medical Society: An Experience in Medical Co-operation," *JISMS* 6 (1916), 241–43.

54. "Report of the Medical Economics Committee," *JISMS* 23 (1933), 364; "Report of the Secretary," *JISMS* 24 (1934), 352. For an example of a contract, see "Excellent Contract for Guthrie County Indigent Sick," *JISMS* 22 (1932), 147–48. For brief descriptions of meetings to discuss negotiations with the county board of supervisors, see meetings of 1/27/1928 and 5/22/1930 in the Bremer County Medical Society Records, 1903–1950, State Historical Society of Iowa, Iowa City. These efforts do not seem to have been successful. A mimeographed copy of the 1933 ISMS fee bill was pasted into this volume, as well.

55. Parker, "Care of the Indigent Sick by Medical Society Contract," 17. A version of this report was published in the *American Medical Association Bulletin* the month before it appeared in the state journal.

56. "Reports from Councilor Districts," *JISMS* 21 (1931), 373.

our troubles" in the Keokuk County Medical Society. "It nearly caused the death of the Society," he claimed, but at least it succeeded in bringing "to the surface the men who are for organized medicine and those who are for their own selfish purposes."⁵⁷

The contract arrangements for seeing patients varied considerably, but before 1934 all of them allowed patients free choice from among the physicians who belonged to the society. To attend to patients who did not have a chosen practitioner, some societies rotated their members through periods of service; others expected the closest physician to handle cases as they came up. In Davenport, Sioux City, and Des Moines, the county medical societies established clinics staffed by volunteers, in which specialists contributed their services to indigent patients referred from a general practitioner. Whatever the details of the contract, county societies frequently reported how much the services they provided were worth compared with the amount they were paid. The Muscatine County Medical Society noted, for example, that in 1932 it dispensed \$13,877 worth of work for a \$3,600 contract. That was hardly satisfactory, but a few societies discovered that if they insisted on better terms without complete cooperation from all physicians, then the board of supervisors would give the contract to a single practitioner or simply dealt with individual physicians' claims for payment as they came in, with their usual tendency to pay less than the fees billed.⁵⁸

As national attention focused on how to deal with the growing number of people who had lost their livelihoods and could barely manage to survive, much less pay for doctors, the way some Iowa county medical societies collectively shouldered indigent medical care became more widely known. In the final report of the national Committee on the Costs of Medical Care (1932), its authors briefly described Iowa's innovation in county-

57. Parker, "Care of the Indigent Sick," 17; "Reports from Councilor Districts," *JISMS* 24 (1934), 363. In 1932 the Hamilton County Medical Society named two members who "have not signed [the] contract and are not considered members." "Reports from Councilor Districts," *JISMS* 23 (1933), 387.

58. John I. Marker, "The County Contract and Clinic," *JISMS* 20 (1930), 86-88; "Three Iowa Societies Tackle Health Center Problem," *JISMS* 20 (1930), 89; "Interesting News," *JISMS* 23 (1933), 110; "Reports from Councilor Districts," *JISMS* 24 (1934), 361-62; "Reports from Councilor Districts," *JISMS* 24 (1934), 359, 361, 363.

TABLE 3 (continued on facing page)
 COUNTY CONTRACTS FOR CARE OF THE INDIGENT SICK IN IOWA, 1930

<i>City or County</i>	<i>Amount</i>	<i>No. in society</i>	<i>No. of Licensed Physicians</i>	<i>Population</i>	<i>Year Contract Started</i>	<i>County Farm</i>	<i>County Jail</i>
Waterloo	\$2000	40	55	36,900	1910	No	Yes
Hardin County	\$1600	28	30	22,320	1904 [?]	Yes	"Any person in Hardin Co."
Fort Madison	\$1200	14	16	11,229	1910	No	Yes
Webster County	\$3000	46	47	21,702	1915	Yes	Yes
Marion County	\$2430	21	25	24,694	1923	Yes	No
Marshall County	\$2000	43	47	33,057	1924	No	Yes
Washington County	\$1800	21	22	19,370	1929	No	No
Jefferson County	\$1600	10	19	16,385	1929	No	Yes
Mahaska County	\$1800	20	29	26,644	1930	Yes	Yes
Scott County	\$12,600	86	101	63,000	1930	Yes	Yes
Council Bluffs	\$6500	41	64	40,900	1930	Yes	Yes

TABLE 3 (cont.)

<i>City or County</i>	<i>Method Used</i>	<i>Disposition of Funds</i>
Waterloo	Rotate: 60 days service per member each year	In society treasury for expenses, dues, etc.
Hardin County	Members answer calls from supervisors or social worker	In society treasury for expenses, dues, etc.
Fort Madison	Rotate each month; each physician takes a turn with the next physician as alternate	In society treasury for expenses, dues, etc.
Webster County	Patient selects physician; authorized by welfare society	Pay members on fee basis
Marion County	Nearest physician attends case	Pay members on fee basis
Marshall County	Patient may choose own physician	In society treasury for expenses, dues, etc.
Washington County	Each patient selects own physician	In society treasury for expenses, dues, etc.
Jefferson County	Eight members rotate monthly; two eye, ear, nose, and throat doctors	In society treasury for expenses, dues, etc.
Mahaska County	Cases rotate; each physician follows each case to completion	In society treasury for expenses, dues, and society endowment
Scott County	Rotating staff at clinic/dispensary	In society treasury for expenses, dues, etc.
Council Bluffs	One physician answers emergency and house calls. Rotate 3-month periods at dispensary and hospital	In society treasury

SOURCE: Robert L. Parker, "Care of the Indigent Sick by Medical Society Contract," *JISMS* 21 (1931), 18-19. See Parker's article for the full table, which includes information on the coverage of major surgery, minor surgery, venereal diseases, and cost of serums, antitoxins, and medicines.

level indigent care, but criticized it as “not well-integrated” with other services, especially hospital care, and poor in its attention to “preventive work.” Medical society contract practice for the indigent provided “inadequate” compensation for physicians and, perhaps most damning, was found, “with one exception, only in small rural communities.” The committee had sought solutions to concerns about access to up-to-date health services for all Americans, so it is not surprising that they did not see much promise in medical society contracts that were limited to care of the very poor. The American Medical Association, in contrast, praised the “Iowa Plan” for its creative response to indigent needs and championed it as a model for managing the expansion of state and federal funding that came with the election of a liberal, Democratic president promising a “New Deal.”⁵⁹

“Government” Medicine: The New Deal and Organized Medicine in Iowa

One of President Roosevelt’s first steps in office in 1933 was to secure passage of the Federal Emergency Relief Act, which gave the Federal Emergency Relief Administration (FERA) a sweeping mandate to relieve Americans’ economic distress by putting the unemployed back to work and, where absolutely necessary, sending direct aid to destitute communities. Iowa first received funds via Civilian Conservation Corps (CCC) and Civil Works Administration (CWA) employment projects in the late winter and early spring of 1933–34.⁶⁰ Federal funds were channeled through the Iowa Emergency Relief Administration (IERA), the

59. Leland, “Some Causes of Professional Unrest,” 604; “Medical Society Experiments in Care of the Indigent,” *JISMS* 29 (1939), 517; *Medical Care for the American People*, 74–75; “Report of the Secretary,” *JISMS* 25 (1935), 356; AMA, *Care of the Indigent Sick*, 40, 49–50.

60. The regulations for CWA work required that the government pay for medical care for employees injured on the job or made ill by diseases caused by the occupation. ISMS physicians were pleasantly surprised by the CWA rules, as they specified that local administrators had to “consult the officers of their county or district medical society” to set up medical aid and to pay for “reasonable medical and hospital services and supplies.” “Medical Care of CWA Workmen,” *JISMS* 24 (1934), 108; Oliver J. Fay, “The Test of Organized Medicine,” *JISMS* 24 (1934), 206. For CCC work, see “Physicians Wanted,” *JISMS* 24 (1934), 586.

state government agency responsible for coordinating relief efforts, ensuring compliance with FERA (and other) regulations, dealing with disputes among counties, collecting data on neediness, and monitoring how money was spent. By early 1935, more than one-third of Iowa's county governments were essentially bankrupt, having reached the maximum amount that they could borrow against the promise of future tax revenues.⁶¹

FERA regulations emphasized the importance of working with state and local professional societies for medicine, pharmacy, and nursing when setting up plans to deal with health needs, especially when devising fee schedules for local services. Any medical plans were to respect the "traditional family and family-physician relationship" as far as possible, with care to maintain a minimum level "consistent with good professional judgment."⁶² By the end of 1934, ISMS officers were deep into discussions with the IERA directors about ways to support county medical relief budgets with state and FERA funds. IERA administrators appointed Dr. Thomas C. Denny, who had spent most of his career employed by the Central Life Assurance Company of Iowa, as director of IERA medical services. He was a fortunate choice, according to the ISMS leadership, as he understood physicians' points of view, but his task was not an easy one. If a county accepted state and federal money, it had to sign on to a centrally regulated program. A certain percentage of the total relief funds coming into each county would be targeted for all medical needs, "and there will be no addition." The central relief office set up "an emergency fee schedule," as well. Dr. Denny stressed that these were "to be accepted as no criterion whatsoever of what a proper fee arrangement should be." Individual physicians had to sign on to the agreement in order to be "eligible to give medical relief service."⁶³ The federal government

61. *Report of the Activities of the Iowa Emergency Relief Administration for the Period January 1933 through December 1934* (Des Moines, 1935), 7. Reports were also printed in 1936 (for 1935), 1937 (for 1936), and 1938 (for 1937).

62. AMA, *Care of the Indigent Sick*, 48, quoting from the 1933 FERA Rules and Regulations.

63. Gordon F. Harkness, "The President's Interim Report to the Members," *JISMS* 25 (1935), 3-4; "Medical Relief in Iowa," *JISMS* 25 (1935), 100; T. C. Denny, "Medical Relief Program," *JISMS* 25 (1935), 153-55. See also *Report of the Activities of the IERA* (1936), 22-23.

dissolved the FERA in 1935, largely because it simply was not working, but Iowa continued to maintain its own office to coordinate emergency relief and distribute meager state funds to needy counties.

Throughout the rest of the 1930s, local arrangements for indigent medical care varied according to the disparities in economic recovery in different parts of the state, the degree of organization within county medical societies, and the cordiality (or lack thereof) between physicians and county boards of supervisors. In the poorest areas, physicians seemed resigned to get what they could simply to support themselves; in other areas conditions were "exceptionally satisfactory" by 1936.⁶⁴ It did not help that physicians in Van Buren County received nearly 100 percent of their billed fees for medical relief work while their county was on the IERA relief roll, but Page County IERA authorities imposed large across-the-board cuts on physicians' charges in that county. "The medical profession is the only group which is asked . . . to accept payment on such an unsatisfactory basis," observed Dr. Treynor of Pottawattamie County. Such complaints ended up in the lap of the ISMS leadership, especially the members of the Committee on Medical Economics, who tried to resolve them at the state level.⁶⁵

In 1937 the ISMS Committee on Medical Economics confronted representatives of the Rural Resettlement Administration (reorganized into the Farm Security Administration [FSA] later that year) over yet another plan that threatened to alienate Iowa doctors even further. The FSA was set up to make limited outright grants and systematic loans to farmers for the supplies they needed to get back into production under a quota system for agricultural products. The watchword was rehabilitation, not relief. Medical expenses were not included in the budgets drawn up with FSA agents, and physicians discovered that farmers who promised to pay them when their FSA loan checks came in always seemed to spend all their cash before putting some towards the doctor's bills. That was not unusual, of course,

64. Ernest E. Shaw, "Various Medical Relief Plans in Iowa," *JISMS* 27 (1937), 589-91; "Reports from Councilor Districts," *JISMS* 27 (1937), 340.

65. "Reports from Councilor Districts," *JISMS* 27 (1937), 340, 343; "Report of the Committee on Medical Economics," *JISMS* 27 (1937), 349-50.

but the physicians expected that since the farmers were enrolled in a federal program, one that promised rehabilitation and ensured that their clients paid full price for seed and stock, they should wisely include medical care under the necessities of life.⁶⁶

Because there were relatively few FSA clients in Iowa compared with the numbers in other states, the ISMS reluctantly agreed to a new, rather experimental plan, which the medical societies in Wayne and Crawford counties accepted on a trial basis. Each farmer in the loan program was to come up with an annual family medical budget in consultation with his or her regular physician, using the ISMS fee schedule and excluding estimates for surgery. That amount would be added to the loan and the funds deposited with a "bonded trustee" picked by the county medical society. If, at the end of the year, funds remained, they would be returned to the client. If, on the other hand, the family needed additional care, the physician would have to provide it without charge.⁶⁷

The description of this arrangement published in the *ISMS Journal* stressed that it was merely proper budgeting and saving, which all families should do, rather than a pre-payment plan of any sort.⁶⁸ But it was yet another system that left physicians both underpaid and providing free service for unanticipated needs. By the end of 1938, the ISMS Medical Economics Committee and the state FSA administrators agreed that the medical funds budgeted for all FSA clients in a county would be deposited as a pooled account with a bonded representative chosen by the county medical society. That money would be used to cover

66. "Report of the Committee on Medical Economics," *JISMS* 27 (1937), 349-51; "Meeting of the Medical Economics Committee," *JISMS* 27 (1937), 439, 444; "Rural Resettlement Program in Iowa," *JISMS* 27 (1937), 493-96.

67. "The Medical Program of the Farm Security Administration," *JISMS* 28 (1938), 108-9.

68. The idea that people with an income below a certain amount should be strongly encouraged—or forced—to have supervised medical savings accounts appears occasionally in these years. See, for example, G. Hubert Artis, "The Open Forum" [letter to the editor about Artis's plan for a "medical budget board" in each community], *JISMS* 23 (1933), 526-27; James C. Hill, "Health Insurance Is Not the Remedy," *JISMS* 25 (1935), 444. Hill attributes the idea to Gustav Hartz, a German labor economist.

medical costs, including emergency surgery but not expensive drugs (such as insulin) or operations for stable chronic conditions (such as hernia), based on a discounted fee schedule. At the end of year, the county medical society could keep any surplus or, as usual, the physicians who cared for the FSA clients would file their unpaid bills with their other uncollectible debts.⁶⁹ It was, obviously, an insurance plan—and an insurance plan involving federal money, with lay employees of the government monitoring it in the background.

Several county delegates at the 1939 ISMS annual meeting were appalled. Stories about the FSA program had circulated in the state: physicians were only getting ten cents on the dollar for their work; clients burdened doctors with trivial calls and demands; FSA clients were not officially indigent, so their neighbors expected the same reduced charges. “If there ever was a step made toward state medicine, this is it,” proclaimed Dr. Harman, a general practitioner from Whiting (pop. 627), to the ISMS House of Delegates. The plan had received “unholy publicity . . . through the editorials in the *Des Moines Register*,” presumably with the permission of the ISMS. “Look at the Dakotas and Oklahoma and see what has happened,” Dr. Harman continued, pointing to states where physicians had resigned themselves to participate in large-scale FSA-run medical collectives. His county medical society (Monona, in far western Iowa) had refused to have anything to do with the FSA program, and he wanted the ISMS to refuse to accept it anywhere in the state. Others urged the delegates to see the counties trying the FSA plan simply as “an experimental laboratory.” The plan was not being forced on every county with FSA clients; that decision remained in the control of the county medical societies, and physicians were not required to participate, although they would have to give up their FSA patients if they refused.

Dr. Shaw, the beleaguered chair of the Medical Economics Committee, reminded the meeting that the House of Delegates

69. “Program for Medical Care of Farm Security Administration Clients in Iowa,” *JISMS* 28 (1938), 628–29; “Program for Farm Security Administration Clients,” Circular letter from E. E. Shaw to all county secretaries, 1/18/1939, in Butler County Medical Society Collection, State Historical Society of Iowa, Iowa City.

had asked the committee to look into pre-payment plans. "There are some doctors who believe we must go ahead with plans if we are to forestall state medicine," he noted. At the end of this acerbic discussion, the House of Delegates voted not to accept the section of the Medical Economics Committee's report covering the FSA system, which was tantamount to censuring the committee's work that would have allowed the plan to be implemented in two of Iowa's counties. That action did not stop the plans, but it certainly removed the Medical Economics Committee's ability to negotiate effectively with FSA administrators on behalf of the ISMS membership. After that, county medical societies dealt with FSA proposals on their own.⁷⁰

Dr. Harman's ire at the FSA group pre-payment plan represents the effect of decades of pronouncements from the AMA, the ISMS, and hundreds of physicians who denounced all forms of contract practice, pre-payment plans, voluntary insurance, and compulsory insurance, whether organized by private companies or by the government. Any arrangement that might involve regulated oversight of the financial relationship between an individual practitioner and his or her individual patient spelled ruin for medicine, proclaimed the loudest voices. Identifying pre-payment plans that would require any form of tax support for employed people as "socialistic" played on diffuse political and cultural fears of threats to American democracy and individualism from the early days of World War I.⁷¹ Voluntary insurance plans, the argument went, inevitably led to compulsory ones, and hence straight into state medicine. In the late 1920s, when workers' compensation laws in some states expanded to cover medical care for specific industrial diseases, physicians bemoaned this tiny slide down the slippery slope. The expansion of veterans' benefits in 1924 to cover medical costs due to

70. "Report of Medical Economics Committee," *JISMS* 29 (1939), 339-40, 349-50; "Report of Medical Economics Committee," *JISMS* 30 (1940), 330-31. For details of the federally sponsored programs in North and South Dakota, see Grey, *New Deal Medicine*, 42-47 and, for the expansion and trials of FSA plans in other states, 53-69.

71. For detailed analysis of the political complexities surrounding the AMA, compulsory health insurance, and American society in the mid-twentieth century, see Gordon, *Dead on Arrival*.

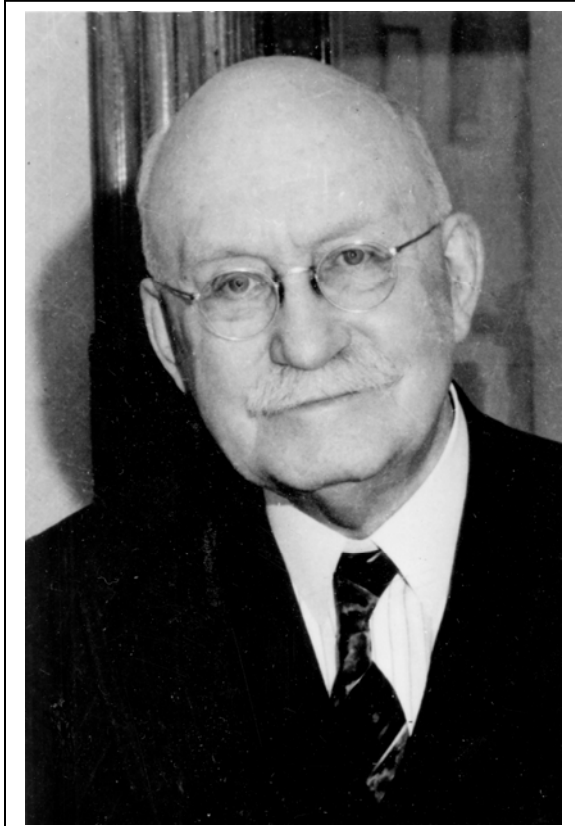
some non-war-related disabilities after World War I similarly pointed to a dire future.⁷²

At the same time that federal politicians and administrators were implementing projects to deal with emergency conditions in the early years of the New Deal, Roosevelt's coterie also launched plans for longer-term programs for the unemployed, disabled, and elderly. At the start, these plans included a system of national health insurance, which immediately encountered determined resistance from the leaders of the AMA. Iowa's Dr. Walter Bierring, who had retired from active medical practice to serve as the Commissioner of the State Department of Health in 1933, was president of the AMA in 1934-35, and Roosevelt's Committee on Economic Security appointed him as a member of its Medical Advisory Board in the fall of 1934. Bierring later claimed that the Medical Advisory Board had played a key role in keeping health insurance out of the draft legislation that the Committee on Economic Security presented in January 1935. Certainly that blue-ribbon panel had influence, as did the strong position the AMA adopted, at a special session of its House of Delegates in February 1935 over which Bierring presided, "to condemn all efforts at regimentation of the medical profession and lay control of medical practice."⁷³

The final provisions of the Social Security Act, which Roosevelt signed on August 14, 1935, did bring unemployment insurance, disability insurance, and old-age pensions to Americans, along with federal resources for some health-related needs, especially those of children. Title V and Title VI provided grants-in-aid (some requiring matching state funds) for maternal and child health, state public health services, hospitalization and medical care for crippled children, and support for homeless,

72. Morris Fishbein, *A History of the American Medical Association, 1847 to 1947* (Philadelphia, 1947), 374; "Forerunners of Sickness Insurance," *JISMS* 21 (1931), 311-12; Bowen, "The Present Status of Medicine," 146; Arthur C. Christie, "The Socialization of Medicine—To What Extent Is It Desirable?" *JISMS* 26 (1936), 499.

73. Walter Bierring, "Federalization of the Practice of Medicine," *JISMS* 34 (1944), 26; Lloyd C. Taylor, *The Medical Profession and Social Reform, 1885-1945* (New York, 1974), 128-32; Walter Bierring, "Special Session, House of Delegates, American Medical Association, Chicago, February 15, 16, 1935," *JISMS* 25 (1935), 152; Starr, *Social Transformation*, 266-70.



Walter Bierring, an important figure in Iowa and American medical history, was Commissioner of the State Department of Health, 1933–1953, and president of the American Medical Association, 1934–1935. Photo from SHSI.

neglected, and mistreated children. Thomas Burcham, president of the ISMS in 1935–36, pronounced all of these worthy measures. There was a resounding lack of protest in the state journal over the next years as Social Security funding—albeit a modest amount—paid physicians for diagnostic clinics (\$3 per hour) and follow-up visits (\$1 per visit) for crippled and chronically ill children around the state, as well as for treatment at the UI hospital. Money to expand the State Department of Health’s staff, to establish county health units with public health nurses, and

to offer refresher courses in obstetrics and pediatrics for Iowa physicians also came through the Social Security program.⁷⁴ With Dr. Bierring as Commissioner of Health (and quite influential in the way Social Security health resources were distributed and administered), it is perhaps not surprising that during these years Iowa doctors only occasionally expressed fears that their expanding public health services competed unfairly with private practitioners. The Social Security Act nevertheless ruffled physicians, for it represented another step in “government controlled services” that, without their constant vigilance, would provide the framework for the complete “socialization of medicine.”⁷⁵

The inflated language of some physicians’ warnings in the 1920s and 1930s, especially when they foresaw that any trajectory toward “socialism” would not stop until “sovietism” — with doctors merely state employees subsisting on meager salaries — did seem hysterical to more sanguine contemporaries, as it has to observers in the post-Medicare and Medicaid era. Some have interpreted the vehemence of physicians’ expressions largely as a rhetorical strategy to frighten Americans into supporting the AMA’s official positions on various issues. Because urban specialists dominated the AMA’s national committees and offices, and similar men tended to be chosen as state delegates to AMA meetings, AMA positions have regularly been interpreted as serving the economic interests of a self-absorbed, wealthy, professional elite, and not those of small-town and rural general practitioners.⁷⁶ Evidence of disagreements and controversies within state medical societies, between state societies and the AMA, and between other physicians’ organizations and the AMA in the 1930s supports the contention that many ordinary doctors were willing to consider both voluntary pre-payment plans and some measure of federal funding for medical care quite apart

74. Thomas Burcham, “President’s Address,” *JISMS* 26 (1936), 332–33; Walter Bierring, “The Social Security Act: Proposed Plan of Operation in Iowa,” *JISMS* 25 (1935), 684–87; “The Present Status of the Medical Social Security Programs in Iowa,” *JISMS* 27 (1937), 122–25.

75. “The Need for Cooperative Planning,” *JISMS* 27 (1937), 217.

76. Starr, *Social Transformation*, 271–75; Oliver Garceau, *The Political Life of the American Medical Association* (Cambridge, MA, 1941), 24–61; Grey, *New Deal Medicine*, 42–47, 66.

from the emergency conditions brought by the Depression. AMA leaders heaped scorn upon physicians who dared to express such views. Such doctors, Dr. R. G. Leland, then director of the AMA's Bureau of Medical Economics, told the annual meeting of the ISMS in 1934, were those "who would sell out the medical profession for a mess of pottage."⁷⁷

Iowa physicians, like so many others, had to come to terms with the conviction that protecting their independence required collective unity and loyalty to the AMA system of county and state medical societies, even if they did not agree completely with the national organization's platform.⁷⁸ Dr. Bowen of Fort Dodge urged that dissenting physicians be "controlled first by moral suasion, and second, by suspension or expulsion from the county society." Dr. Henry Young, an ophthalmologist from Burlington, bluntly laid it out for readers of the *ISMS Journal*. The AMA, he stated, had long pretended to be a "scientific body" when its main purpose had really been, and certainly was, "politics." He had been quite satisfied with belonging to his specialty societies, and his "twenty years of isolation (outside the pale of organized medicine) was, in itself, proof that the medical man, seriously and honestly disposed, did not need the organization as much as the organization needed him." But conditions had changed. Membership in the AMA, he argued, "should be compulsory, under pain of ostracism." Addressing an obvious objection, he continued, "Sounds like trade unionism, doesn't it? Well, like it or not, that's the least of the degradations impending. Hanging together, in every sense, is better than hanging separately."⁷⁹

77. Leland, "Some Causes of Professional Unrest," 607; Fishbein, *A History of the American Medical Association*, 389, 1096.

78. The Pennsylvania State Medical Society's Board of Trustees' charges to its county societies, printed in the *JISMS* "because of the aptness . . . of these statements," declared that physicians speaking for their county society should, "in all discussions with lay individuals or groups or legislators, discuss *only* the ultimate deteriorating effects on the quality of medical service that have always accompanied the socialization of medical practice." "To Meet the Changing Times," *JISMS* 23 (1933), 475. See also Fay, "The Test of Organized Medicine," 205-8; and Harkness, "The President Elect's Address," 272.

79. Bowen, "The Present Status of Medicine," 147; H. B. Young, "A Reorganized Medical Profession" [letter to the editor], *JISMS* 24 (1934), 108-9.

As Iowa physicians in county medical societies all over the state discussed plans to care for the indigent in the early 1930s, it is likely that the reality of “government” medicine struck home for many of them for the first time. “Government” medicine was not a distant menace, but present down the road in meetings of the county board of supervisors and, shortly thereafter, at the offices of county relief agents who were in charge of dispensing state and federal aid if the county qualified. When the county medical society doctors and local officials got on well, with everyone understanding that extremely low fees were only a temporary response to an emergency condition, then hardship was almost ennobling. Linn County authorities and physicians “are enthusiastic about the spirit of unselfishness, self-sacrifice, and willingness to abide by rules intended to promote the greatest good for the greatest number,” Dr. Downing reported to the ISMS in 1935. At the other extreme, discord gave weight to all the rhetoric about socialized medicine. The Pottawattamie County medical society expressed its grievances with IERA administration in 1937. “The IERA authorities have continued to be rather arbitrary in their promulgation of instructions,” Dr. Treynor complained, “usually failing to consult the doctor or take him into consideration before such instructions are issued.” Over and over again, reports from the county medical societies confirmed that things worked best when physicians had as much collective control as possible and worst when lay people told them what to do. And lay people from outside—outside the community, but especially from outside the state—were even harder to take. “Are we to be standardized? Are New York’s problems our problems?” Dr. Harkness blustered in 1934. “Do we have to sit supinely by and have salaried employees from a foreign environment, whose very jobs depend on the changes they can suggest, come to us, tell us just what we should do, and should we blindly accept their decisions as gospel truth?”⁸⁰ Being instructed, not consulted, touched doctors’ pride, no matter what ended up in their pockets.

80. “Reports from Councilor Districts,” *JISMS* 25 (1935), 377; “Reports from Councilor Districts,” *JISMS* 27 (1937), 343; Harkness, “The President Elect’s Address,” 272.

Physicians' experience with indigent care was also shaped by their patients' status as *indigent*, a formal classification determined by county officials, not by individual practitioners. The label carried a stigma that brought contempt as well as compassion. A few Iowa physicians articulated attitudes of disdain towards those who were "improvident" rather than "thrifty." In 1938 Dr. Harkness noted that Davenport physicians acquiesced with the local relief plan, which did not allow indigent patients free choice of physician, because it was "in the interests of economy" that "the recipient of charity, paid for in taxes, should be willing to forego this privilege." Dubuque County doctors reported that they willingly accepted the burden of making private arrangements with "families who were without funds but who still retained enough American spirit and backbone to refuse to 'go on the county.'" Caring for their patients' dignity enhanced their own. At the same time, this experience resonated with language that cast every tax-supported scheme as socialized medicine, in which "universal paternalistic care lowers [the patient's] self-pride and his standard of citizenship." With state medicine, "we approach a disguised dole, we foster 'moral gangrene.'"⁸¹

The problem with dignity, however, was that it kept those who were not "on the county" from seeking medical help when they needed it but could not pay for it. The difficulties that people with low or moderate means had paying for acceptable medical care, especially when it involved complex surgery, long hospital stays, or new drugs, had surfaced as a national concern in the 1920s. One response from physicians was simply to castigate people for not saving money properly, a tempting gambit when national data from the late 1920s showed that the average family spent far more per year on tobacco, candy, soft drinks, gum, ice cream, perfume, cosmetics, and nice soap than it did on drugs, physicians, hospitals, nurses, and dentists.⁸² By the

81. "Report of the Committee on Medical Economics," *JISMS* 23 (1933), 415; Gordon F. Harkness, "A Doctor Contemplates the Care of the Sick," *JISMS* 28 (1938), 408; "Reports from Councilor Districts," *JISMS* 24 (1934), 359; Gordon F. Harkness, "The Cost of Being Sick," *JISMS* 23 (1933), 40.

82. Harkness, "Cost of Being Sick," 32, citing W. C. Rappley, "Comparative Expenditures for Medical Care," *JAMA* 94 (1930), 1787 (no source for data).

early 1930s, however, most doctors knew full well that while people with more than marginal incomes managed to afford the costs of physicians' visits for minor illnesses and preventive vaccinations, it was the major illnesses and injuries, complex diagnoses, and difficult chronic conditions that had become unbearable financially even as medical help now existed to deal with them. As a result, patients stayed away due to fear of the cost. "The great middle class of people . . . is composed of decent, independent, honest and honorable people," Dr. Channing Smith of Granger reminded his colleagues in December 1933. "These people are just as good as you and I, are just as hard pressed as we are," he insisted, "and their problems of medical care are our problems as well." Something had to be done, but, Dr. Smith confessed, "I frankly do not know what the answer is to these many problems."⁸³

Smith was not alone in his frustration. Ordinary physicians had a hard enough time keeping their own businesses straight; how could they figure out what was to be done to pay for the diagnostic tests, drugs, and operations that medicine could provide? Physicians could modify their own fees based on what they knew of their patients' circumstances, but they had no direct control over other costs, including the bills of specialists who had to be consulted in large towns and cities. Dr. Harkness told his colleagues in 1933 that "lay organizers filled with Utopian enthusiasms" had raised their poorer patients' expectations for elaborate care. "The wealthy may pamper themselves with all the frills if they so desire," he stated, "but the mass of people should realize their inability to pay for them." Most people, he continued, did not need the "diagnostic frills" that were only available in hospitals. Two years later, when Dr. Harkness was president of the ISMS, he was adamant that physicians had to keep medical relief costs down in order to preserve local control over indigent care. "If we neglect this we are inviting socialized medicine," he warned. "There is no justification for rewarding indigency with the frills of scientific medicine."⁸⁴

83. Channing G. Smith, "What of the Future?" *JISMS* 23 (1933), 682 (first printed in *The Voice*, the bulletin of the Black Hawk Medical Society, in 1933).

84. Harkness, "Cost of Being Sick," 40; Harkness, "The President's Interim Report," 4.

Making physicians largely responsible for medical costs by ensuring that tests, drugs, and hospitalization were ordered “efficiently and not extravagantly” placed a new burden on practitioners providing indigent care through programs run by their county medical societies. Physicians now had to be sensitive to the drain on funds supervised by their colleagues, funds that other physicians depended on for at least some income during these difficult years. Many doctors may have shuddered at Harkness’s harsh language in regard to the very poor, but they could not avoid reiterating the basic message: if you do not make these choices, others will do it for you. State scrutiny of medical relief costs for the indigent turned up widely varying usage patterns, which further increased the pressure on the profession. “When a director of relief asks why in one county the proportionate hospitalization costs are approximately nine times (according to the case load of indigency) what they are in a nearby county,” Harkness warned, “we must be prepared to show justification for this difference.” Physicians in at least some of Iowa’s county medical societies took on the task of monitoring their colleagues’ bills for indigent work. Subcommittees met each month to vet members’ charges before they were forwarded to the board of supervisors for payment, reducing them if necessary. The occasional frank report from a county medical society to the annual meeting of the ISMS House of Delegates demonstrated that not all members had personally taken cost containment enough to heart, forcing the society to intervene. In 1938 the president of the Emmet County Medical Society had to appoint a subcommittee to “see that county cases are not overhospitalized and so prevent abuse of funds provided for the hospital budget.” Dr. Dewey reported that the board of supervisors and members of the Sac County Medical Society were not getting along as well as they had been in previous years, “due to some overpadding of bills and some ruthless cutting of the same.”⁸⁵

85. Harkness, “The President’s Interim Report,” 4; “Reports from Councilor Districts,” *JISMS* 25 (1935), 371, 379; “Reports from Councilor Districts,” *JISMS* 27 (1937), 326, 334–35; “Reports from Councilor Districts,” *JISMS* 31 (1941), 313; Meeting of the Bremer County Medical Society, 2/1/1935, in their volume of minutes, State Historical Society of Iowa, Iowa City; “Reports from Councilor Districts,” *JISMS* 29 (1939), 311, 314.

For many ordinary practitioners in Iowa, the 1930s brought the first small taste of external inspection of patient billing, apart from any workers' compensation practice they may have had in the 1920s. Physicians active in the county medical societies with contracts for indigent care discovered that they or their peers could review each other's indigent accounts without intolerable embarrassment or conflict. As debates raged about ways to make health care affordable to low- and middle-income people, especially the costs of major trauma and sickness, a good many Iowa physicians were actually experiencing what it was like to try to cooperate with other practitioners to manage care for a specific population on a limited budget. At the same time, they reacted to the perceived injustices and irritations of localized "government" medicine. The call to resist plans for state-run medical care by participating in "organized" medicine, the medicine of their county and state medical societies, thus drew Iowa's physicians into the fold. In 1929, 77 percent of the state's practicing physicians belonged to the Iowa State Medical Society (and hence to the AMA); in 1939 membership was up to 91 percent; in 1946 it reached 96 percent, where it remained through 1950. As the Depression drew to a close, organized medicine held firm against tax-funded general medical services and, albeit reluctantly, turned to voluntary, private, non-profit insurance as the solution to covering the costs of health care for Americans. A key point for organized medicine, however, was physician control over the principles guiding acceptable medical plans and physician participation in their governance. This ideal gave the ISMS leadership considerable pride—and a great many headaches.

Resisting "Government" Medicine: Voluntary Health Insurance in Iowa

The story of the emergence and expansion of what eventually became the national Blue Cross and Blue Shield system is a complex one. It started with plans for paying for hospital care. In 1929 Justin Ford Kimball, an administrator at Baylor University with a background as an insurance lawyer and superintendent of schools in Dallas, devised a non-profit pre-payment plan

for Baylor University Hospital to be offered to all the teachers in the Dallas school system. The Baylor plan was by no means the first hospital-centered group plan, but it is the one that later came to be associated with the turning point between sporadic efforts and successful long-term growth in non-profit hospital insurance. The problems that earlier programs had had with competition among hospitals and inadequate numbers of subscribers had convinced skeptics that voluntary hospital prepayment plans would never work, especially for small-town and rural populations.⁸⁶ Plans grew steadily in urban areas, however, once all or most of the local hospitals joined together under the same program and learned how to negotiate with employer and labor groups for significant contracts. Throughout the expansion of community-based, non-profit hospital insurance plans, the American Hospital Association (AHA) provided a clearinghouse for ways to manage income and costs. The AHA's Committee on Hospital Service also established a set of essential principles that became formal guidelines in 1937. If a plan passed AHA scrutiny every year, it could use a common seal of approval—the Blue Cross.⁸⁷

A major sticking point surfaced repeatedly, however. Subscribers expected that coverage of hospital costs should include physicians' services, especially those of radiologists, anesthesiologists, and pathologists, the specialists who worked full-time within the hospitals' walls. In the mid-1930s, the AMA reluctantly accepted the emergence of hospital plans, which it carefully called "group hospitalization" rather than "health insurance," as long as those plans never included any billing or payment of physicians' charges. The slippery slope toward socialism would be avoided "so long as the medical profession remains in control."⁸⁸ Getting separate, additional bills from

86. Robert Cunningham III and Robert M. Cunningham Jr., *The Blues: A History of the Blue Cross and Blue Shield System* (DeKalb, IL, 1997), 3–17; Bowen, "The Present Status of Medicine," 147. A few hospitals in Iowa started contracts with county boards of supervisors in the early 1930s, negotiating a total number of days covered for a lump sum. See, for example, "Reports from Councilor Districts," *JISMS* 24 (1934), 359.

87. Cunningham and Cunningham, *The Blues*, 17–33.

88. Christie, "The Socialization of Medicine—To What Extent Is It Desirable?" 502.

physicians for their fees for in-hospital work nevertheless angered and confused patients, who, reconfigured as “consumers” when very large employee contracts were at stake, put considerable pressure on hospitalization insurers to provide full-service benefits. Those putting together hospital plans in urban areas put pressure on physicians, often through their medical societies, to come up with some sort of pre-payment program for medical care.

Iowa physicians reading the *ISMS Journal* found notices about the experiments in hospital pre-payment schemes going on in Texas, New Jersey, California, and elsewhere in the early 1930s alongside the more general discussions of relief work and threats of socialized medicine.⁸⁹ The Sentinel Hospital Insurance Company started the first hospitalization plan in Iowa late in 1936. By April 1938, after changing its name to the Iowa Hospital Service Insurance Company and putting three physicians on its board, the company had 2,500 policyholders.⁹⁰ The ISMS Medical Economics Committee decided to “withdraw all semblance of approval of the company,” however, when it became a “general casualty company” later that year. At that point, the ISMS joined with the Iowa Hospital Association to push for legislation to exempt non-profit group hospital insurance from some of the requirements imposed on for-profit insurance companies, notably the need to have a \$25,000 cash reserve at all times.⁹¹ Such legislation passed in 1939, and a revised hospital insurance plan—Hospital Service, Inc.—formally started on December 1, 1939, in Des Moines. With genuine non-profit status under the new law, Iowa’s Hospital Service, Inc. gained AHA

89. “Hospital Plan in Dallas, Texas,” *JISMS* 22 (1932), 594.

90. “Hospital Insurance in Iowa,” *JISMS* 28 (1938), 159–60. In addition to the plans discussed in this section, some fraternal organizations in Iowa, such as the Lutheran Mutual Aid Society, the Order of Railway Conductors, and the Brotherhood of American Yeomen, provided medical and disability benefits. See State of Iowa, Insurance Department, Annual Reports, 1929 and 1930, in State of Iowa, *Legislative Documents*, vol. 3 (Des Moines, 1931), 202–27. How long these groups provided some sickness benefits, in addition to death and old age benefits, and the extent of their coverage for Iowans, requires further research. For the still under-appreciated importance of the history of fraternal organizations in health organizations, see James C. Riley, *Sick, Not Dead: The Health of British Workingmen during the Mortality Decline* (Baltimore, 1997).

91. “Report of the Medical Economics Committee,” *JISMS* 29 (1939), 339.

approval in 1940 and, with that, the Blue Cross seal. At the same time, however, another non-profit hospital plan, Associated Hospital Service, Inc., emerged in Sioux City. In the months before the two corporations agreed on a boundary between their service territories (which basically gave the far northwest corner of the state to the Sioux City group), Hospital Service, Inc.'s new staff faced the anxiety of competition in what was supposed to have been an understood non-profit monopoly.

The ISMS urged all physicians to join Hospital Service, Inc., using county medical societies as the basis for group enrollment. "The support of the medical profession . . . will be of great value in presenting the service plan to employers and employees in the various communities as they are organized," the *Journal* editors declared in March 1940.⁹² As much as Hospital Service, Inc. needed to show that physicians personally approved of the insurance, the company also needed the money. Keeping enough coming in from premium payments to cover the costs of claimed services was, and remained, a major challenge. Over the next years, even as war further complicated efforts to deal with medical needs, the plan's administrators worked to find groups, such as farmers' organizations, that would allow rural inhabitants and the self-employed to enroll, at the same time that they sought subscribers among the regularly employed.⁹³

At the same time that the ISMS leadership was trying to get non-profit, voluntary hospital insurance off the ground in the state, the society's delegates agreed that "study and experimentation with voluntary health insurance plans should be undertaken." The Medical Economics Committee proceeded to "study" such plans off and on for the next six years. In April 1944, when it looked as though the end of the war just might be in sight, the ISMS House of Delegates finally resolved that a committee had to put together a physician-run plan for Iowa within the next few months. On November 1, the delegates met in a special session

92. "Hospital Insurance in Iowa," *JISMS* 30 (1940), 125; "Hospital Insurance in Iowa," *JISMS* 28 (1938), 159-60; "Hospital Service Insurance," *JISMS* 29 (1939), 218-19.

93. "Hospital Insurance in Iowa," *JISMS* 30 (1940), 125; "Blue Cross Plans Approved," *JISMS* 37 (1947), 174. Cunningham and Cunningham, *The Blues*, 57-87, covers the complexities of the 1940s.

to consider the proposal their colleagues had prepared. A renewed sense of urgency spurred the discussion. The threat of legislation for national health insurance simply would not go away, and state legislatures were starting to consider their own compulsory plans. Thousands of "our people" would be coming home after being used to complete medical service in the military. The costs of care for serious illness and injuries continued to burden hard-working families of modest means. Something had to be done. As important as some of the provisions of the first plan were, moreover, the delegates' primary task was far harder—to decide whether they, or the physicians they represented, really wanted a plan for which the ISMS itself would be responsible.⁹⁴

As ISMS president-elect Dr. Bernard told the meeting, "for the first time the State Medical Society is going into business. It is going into a business with which a very high percentage of the men are unfamiliar." One of the first steps, indeed, would be to get legislation passed that would allow physicians to incorporate in the state for business purposes. The State Insurance Commissioner would have to approve the plan, and would pay particular attention to whether or not it was "actuarially sound." Premiums and costs had to stay low; to manage that the proposal centered on a service-based contract for low-income subscribers, with an indemnity plan for those above a set income. Under the service portion, the plan would pay doctors according to a set fee bill for their services in hospitals. For those with indemnity coverage, the plan would pay doctors the same fee bill amount, but the doctors could then charge their patients whatever additional fee they felt they deserved for their in-hospital visits and services. Every physician who signed up to be a future provider would have to contribute at least \$25 to the start-up reserve fund, in addition to an unspecified lump sum that the ISMS would give from the society's savings. If income from subscribers did not cover payments to physicians accord-

94. "Special Session of House of Delegates of the Iowa State Medical Society," *JISMS* 28 (1938), 497; Committee on Medical Economics, "Medical Service Plans," *JISMS* 32 (1942), 133-34; "Iowa Medical Service Plan," *JISMS* 34 (1944), 438-39; "Transactions of the House of Delegates, Iowa State Medical Society, Special Meeting, November 1, 1944," *JISMS* 34 (1944), 500.

ing to the fee bill, moreover, doctors' compensation would be temporarily reduced. The Blue Cross offices, luckily enough, had agreed to take on the work of selling the policies—for a reasonable charge—since their staffs were already experienced, and selling medical coverage fit nicely with selling hospital insurance. Physicians had to realize, however, that “the solvency of this organization is in your hands” and that they were ultimately the ones who would “sell” the insurance to the people in their communities.⁹⁵

Not surprisingly, once the floor at the delegates' meeting was opened to general discussion, concerns surfaced. Who, exactly, would control the new business: elected men? appointed men? representatives from each district? specialists? Were the delegates “being railroaded a little”? Dr. Dean Harman of Mills County finally spoke out about the basic injustice of the proposed system: it limited coverage to physicians' fees during hospitalization. He protested:

Our hospital facilities are from twenty to thirty-five miles away. The adoption of this plan . . . would mean that the general practitioners in Mills County would become nothing more than glorified office boys. Must we take everybody to a hospital? Ninety per cent of our fractures are handled at home, 95 per cent of our obstetric cases, and I will say 85 per cent of our medical cases. Given universal distribution of this plan, along with the Blue Cross, as soon as we make a diagnosis they will want to go to a hospital, naturally. That ends us. What do you want us to do? To sell apples on the street corner? . . . The fee bill takes care of the surgeon very well, but what does it do to the medical man?⁹⁶

Several rural general practitioners agreed with Dr. Harman, but argued that they trusted the ISMS physicians who had put together the plan as a starting point for non-profit, physician-controlled voluntary insurance in the state. As one delegate put it after listening to the debate, “I am going to depend upon the future to make [the plan] right with the physicians in the rural districts.” Other doctors basically admitted that they had to

95. “Transactions of the House of Delegates, Iowa State Medical Society, Special Meeting, November 1, 1944,” *JISMS* 34 (1944), 500-504.

96. *Ibid.*, 509.

trust the men who had examined the intricate details of the medical insurance business and so knew what would work and what would not.⁹⁷

With final expressions of faith and optimism, the delegates finally passed the principles of the plan. Governor Robert Blue signed the enabling legislation on February 15, 1945, and the new non-profit corporation, the Iowa Medical Service, sold its first policies in September. By March 1946, the service's board had dropped "the hospitalization clause . . . from surgery, obstetrics and fracture work" to "benefit the small town doctor." At first sales went reasonably well. In July 1946 Iowa Medical Service had 827 participating doctors—approximately one-third of the state's licensed physicians—and 12,500 people enrolled. Because at least half of a county's physicians had to be enrolled as providers before policies could be sold in it, however, coverage over the state varied considerably. In counties with a dozen physicians or less, it did not take many to prevent the plan's expansion into certain areas, and growth soon slowed. Dr. Fred Sternagel, who chaired the ISMS's Committee on Medical Service, berated the state's physicians in 1948: "Ominous signs of selfishness, suspicion and indifference among many of our members threaten to ruin the whole program—selfishness and suspicion spawned in a period of materialistic ambitions and indifference cradled by a false sense of security." Similar messages came in the late 1940s from national leaders, who continued to link the possible failure of voluntary insurance with the inevitability of a compulsory national health care system. "If the medical profession does not at once assume the leadership, if it does not at once cease its double talk and double dealing with the voluntary non-profit pre-payment plans, and throw its influence squarely and honestly behind these plans, we are going to have compulsory government health insurance in this country within three years," Dr. Paul Hawley, chief executive officer of the newly organized Blue Cross-Blue Shield Commission, told readers of the *ISMS Journal* in August 1948.⁹⁸

97. *Ibid.*, 511.

98. *Ibid.*, 512; "House of Delegates Approves Medical Service Plan for Iowa," *JISMS* 34 (1944), 496-97; "Reaction of Physicians to Medical Service Plan," *JISMS* 36 (1946), 110-11; "Status of the Medical Service Plan," *JISMS* 35 (1945), 89;

The Iowa Medical Service joined the national Blue Shield group in 1946, as that organization sought to help physician-controlled voluntary plans (whether for profit or non-profit at first) with information, coordination, and, eventually, ways to transfer payments among plans as subscriber contracts increasingly crossed multiple plan areas.⁹⁹ Perhaps the increasing national visibility and relative stability of Blue Shield corporations, along with the ongoing fear of “government” medicine, encouraged more Iowa doctors to participate in the plan. In early 1947, as well, the Iowa Medical Service became the contracting agent for the Veterans’ Administration’s “Home Town Medical Care Plan,” which allowed the 340,000 Iowa veterans to see their local physician for service-related conditions and pension authorizations instead of traveling to a VA clinic or hospital. Physicians who wanted to participate in the program had to register with the Iowa Medical Service.¹⁰⁰ They did not have to belong to the ISMS plan itself to care for veterans, but filling out the paperwork for one may have prompted doctors to send in their forms for the other. By April 1950, 78 percent of the physicians in practice in the state were Blue Shield providers, and the Iowa Medical Service—at least for the moment—was comfortably in the black. Only some 200,000 Iowans, or slightly less than 8 percent of the state’s residents, were covered by the plan, however.¹⁰¹

“Iowa Medical Service,” *JISMS* 36 (1946), 299; “Report of the Committee on Medical Service and Public Relations,” *JISMS* 38 (1948), 314–16; “Problems of Medical Service in Iowa,” *JISMS* 37 (1947), 511; Paul R. Hawley, “Blue Shield, or Compulsory Government Insurance,” *JISMS* 38 (1948), 382; “First National Public Relations Conference,” *JISMS* 39 (1949), 29.

99. “Associated Medical Care Plans,” *JISMS* 36 (1946), 255. This organization of medical plans did not officially adopt the Blue Shield symbol until 1951, but individual state plans had used it freely from the early 1940s. Cunningham and Cunningham, *The Blues*, 51–52, 72–73.

100. “Veterans Affairs Committee,” [discussion of the ISMS House of Delegates meeting, 4/19/1946], *JISMS* 36 (1946), 320–21; “Present Status of the Veterans Administration Program in Iowa,” *JISMS* 36 (1946), 405–6; Martin Olsen, “New Medical Service Director,” *JISMS* 37 (1947), 136; “Veterans Administration,” *JISMS* 37 (1947), 175, 180, 425–26; “The Medical Service Plan,” *JISMS* 37 (1947), 298.

101. “Report of Sub-committee on Insurance,” *JISMS* 40 (1950), 349.

HOW 600,000* IOWANS BENEFIT FROM THEIR OWN HEALTH PLAN



**NOW 1 OUT OF EVERY 4 IOWANS SHARE
NEW SECURITY FROM THE HIGH COST OF SICKNESS**



Do you know that 1 Iowan in every 8 will have to go to a hospital this year? Cost of sickness today runs higher than ever before. In many families a serious illness could wipe out their savings. But, now, more than half a million Iowans have solved this problem for themselves . . . and at nominal cost. They enjoy worry-free security from hospital and medical bills through their own community-sponsored, non-profit health plans . . . Blue Cross & Blue Shield.

**The Lowest Possible Cost
For The Greatest Possible Protection**

These non-profit community programs of the Blue Cross Hospital Plan and Blue Shield Medical Plan have brought a new day in freedom from the worry over hospital and medical bills for 1 in every 4 Iowans. These voluntary programs are sponsored by Iowa hospitals and doctors with community cooperation. Because they exist only to serve subscribing members, Blue Cross and Blue Shield give you the MOST protection at the LOWEST possible cost.

What Blue Cross & Blue Shield Offer to You . . .

For amazingly small monthly payments . . . a few cents a day . . . Blue Cross pays for hospitalization, ranging from one person to the entire family, as desired. At slight additional cost, Blue Shield

provides equally great benefits for surgery in hospital, office, or home, as well as doctor's care in the hospital.

Who Can Belong

Blue Cross and Blue Shield voluntary membership is available to EVERYONE in a job where there are 8 or more people employed, or through rural Health Improvement Association in nearly all Iowa counties. If your plant, store or office does not as yet have Blue Cross-Blue Shield protection, mail the coupon below for complete literature and information. If you live in a rural community or on a farm, ask about Blue Cross-Blue Shield at your hospital or doctor's office. Enjoy the freedom from worry that only Blue Cross and Blue Shield can provide.

If you are already a Blue Cross-Blue Shield member, your membership card is the greatest assurance of worry-free health security that can be had.

If you are not yet a member, mail the coupon below.



Blue Cross-Blue Shield
Liberty Bldg., Des Moines 9, Ia. DEPT. 1-2180

Please explain the benefits I can receive in Blue Cross and Blue Shield.

Name

Address or R.F.D.

City..... State.....

Co. where employed.....

Number of persons where you work.....

*600,000 Blue Cross members
175,000 Blue Shield members



Blue Cross Blue Shield of Iowa took out this newspaper advertisement to tout its success in securing members and to promote itself to potential new members. From Iowa City Press-Citizen, February 19, 1950.

World War II: Military Service, the Home Front, and Postwar Iowa

As hard as some of Iowa's physicians worked to get non-profit, voluntary hospital and medical insurance plans off the ground between 1939 and 1947, such enterprises were certainly not the main focus of Iowans' preoccupations during these years. Threats of war, war itself, and postwar adjustment reshaped many doctors' lives. World War II had a much deeper effect on Iowa medicine than World War I had, largely due to the ways the Second World War intensified already ongoing changes in medical knowledge and practice. Not least of these changes was the expanding involvement of the federal government in scientific research as well as health policy, the increasing status of board-certified medical specialists, and the stepped-up emphasis on the need to build more hospitals. The war also tested Iowa physicians' voluntarism and sense of public duty in new ways, as military demand for doctors drained the state of young, able-bodied male practitioners, nurses, and support staff.

Official preparation for the medical needs of a military alert to war began in 1940, starting with the recall of medical reserve officers to active duty in the spring.¹⁰² In June the Surgeon General asked the AMA leadership to gather data on "the medical strength" of the country. The AMA created its Committee on Medical Preparedness and asked every state society to appoint a state chairman to organize local responses. Dr. Thomas Suchomel, a general practitioner in Cedar Rapids, took on this thankless task for Iowa, and he chaired the ISMS Medical Preparedness Committee (later renamed the Procurement and Assignment Service under the War Manpower Commission) until it formally dissolved on March 31, 1946.¹⁰³

Dr. Suchomel's first job was to oversee the staffing of local draft boards with physicians who would examine recruits and report to the board on their physical and mental health. At a national conference on medical preparedness held in Chicago in

102. "Army Experience for Physicians," *JISMS* 30 (1940), 169.

103. Thomas F. Suchomel, "Report of the Committee on Medical Preparedness," *JISMS* 31 (1941), 326-29; Thomas F. Suchomel, "Report of State Chairman of Procurement and Assignment Service," *JISMS* 36 (1946), 314-15.

late September, "those present" decided that "examining physicians should not be paid for their services but should make them their patriotic contribution to the government." They would receive "some sort of badge and certificate" from the president of the United States to acknowledge their work, however. In addition, each county was to put together a Medical Advisory Committee, consisting of various specialists, including a dentist and chiroprapist, to assist examining physicians with consultations. (The national leaders seemed to assume that every county actually had a slate of specialists.) Draftees passing this stage of induction were then seen by the Army Induction Board, where medical reserve officers and paid civilian consultants would make the final assessment of the young men's suitability for military service.¹⁰⁴

When the United States entered the war on December 8, 1941, the draft went into high gear. All physicians were urged to register immediately with the AMA's Procurement and Assignment Service. If they did not, male doctors under the age of 45 could be drafted for unclassified service and have a medical commission considerably delayed. All physicians, including women, the physically disabled, and those older than 45 had to register, moreover, so that state Procurement and Assignment Services could try to maintain an equitable distribution of doctors. Physicians declared "essential to the proper medical care of the civilian population" would be deferred from service. Medical students, professors, and a limited number of residents were also placed on deferment, at least for the time being.¹⁰⁵ Medical schools went year round, and all eligible students were required to take military commissions, which, after a nine-month internship, would place them in active service unless they qualified for one of the limited number of residencies deemed vital for the war effort. The Selective Service also had a direct say in the entry of new students into medical schools as the war continued. Despite the obvious need for new practitioners, the number of women students at the UI medical school remained

104. "Medical Preparedness—How It Is To Work," *JISMS* 30 (1940), 495–96.

105. "A Call to the Medical Profession," *JISMS* 32 (1942), 26; "National Conference on Medical Service," *JISMS* 32 (1942), 134–35; "Medical Preparedness," *JISMS* 32 (1942), 84–85. See also "Medical Preparedness," *JISMS* 31 (1941), 36–37.

at its prewar level of four to five percent.¹⁰⁶ The relatively small number of women (and of men ineligible for military service) who managed to graduate between 1942 and 1945 simply could not fill the demand for interns or community practitioners left in the wake of war.

Throughout the war, the War Manpower Commission relied on the medical profession to recruit its own members for military needs, rather than resort to forced induction of doctors, although it did establish state quotas.¹⁰⁷ Such privileges placed considerable burdens on state chairmen after the first rush of patriotic fervor brought out the volunteers. Iowa proudly came through with 122 percent of its quota for 1942—unlike New York, Connecticut, and Massachusetts, which had not met even 90 percent of their 1942 quotas by May 1943. Physicians even came out of retirement to lend a hand. Dr. William A. Howard, for example, “formerly retired and living near Cherokee, has located in Truro, where he . . . will occupy the offices of Dr. Herbert N. Boden who has entered the military service.” By the spring of 1943, however, Dr. Suchomel had started to feel the pinch as voluntarism faltered. Physicians who could not meet the physical requirements for military service, for instance, could be classified as able to be relocated in order to release a young, willing doctor who had been considered “essential” in his community. Suchomel openly expressed his frustration with three doctors “who have flatly refused to cooperate” with requests to relocate, and wished he had the authority to force them to submit.¹⁰⁸

106. Anderson, *Internal Medicine*, 79. For general assessments of the absence of women from medical education in the 1930s to 1950s, see Regina Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York, 1985); and Ellen More, *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850–1995* (Cambridge, MA, 1999). Details on the specific policies and decisions affecting the admission of women and minorities to medical schools in the twentieth century await the work of those with access to the internal records of admissions committees.

107. Roy W. Fouts, “Procurement and Assignment of Physicians,” *JISMS* 32 (1942), 228–31. The army and navy did recruit physicians directly, which made the AMA’s system work unevenly, although it did not become as marginal in Iowa as some accounts suggest it did at the national level. See, for example, Anderson, *Internal Medicine*, 79.

108. “Procurement and Assignment Outlook,” *JISMS* 33 (1943), 21; “Statements Concerning Procurement of More Physicians to Meet Nation’s Military and

The physicians who did stay in Iowa certainly found their responsibilities increasing. In addition to the extra patient loads and indigent work they shouldered, many physicians were urged to participate in community service activities that had started before the war and continued during these difficult years. County medical societies trying to foster good relationships with the State Board of Health and various lay organizations wanted to maintain their cooperative programs, including annual drives to vaccinate infants and young children against smallpox and diphtheria, tuberculosis screening clinics, and health projects for 4-H groups. When fuel and food rationing started, physicians found that they were responsible for filling out forms to attest that the sick and vulnerable needed extra supplies. Some of the doctors who had started to specialize had to devote more time to general practice, while those near hospitals that had come to rely on full complements of interns and residents for night duties had to take turns staying in the hospitals as the War Manpower Commission siphoned off interns and residents for military work. At the annual ISMS meetings in 1943 and 1944, district councilors reported on the stresses facing the "older doctors," who were "giving of their time and strength almost to the breaking point." The councilors assured each other that no one "was suffering from want of adequate medical care," yet when Des Moines County had "only 23 doctors to look after the needs of about 50,000 persons," some of those needs must have gone unnoticed.¹⁰⁹

Wartime conditions at home also inspired new language about the value of the physician's time. A 1942 editorial in the *ISMS Journal* declared that medical service had already become

Civilian Needs," *JISMS* 33 (1943), 271; "Personal Mention," *JISMS* 32 (1942), 148; "Transactions of the House of Delegates [discussion period]," *JISMS* 33 (1943), 337. For earlier resistance to the demands of the Committee on Medical Preparedness, even for information about practitioners from county medical societies and individuals, see "Report of the Committee on Medical Preparedness," *JISMS* 31 (1941), 327; and "Report from Councilor Districts," *JISMS* 31 (1941), 310 [Scott County].

109. See "Reports from Councilor Districts," in *JISMS* 31 (1941), 297-315; *JISMS* 33 (1943), 320-22; *JISMS* 34 (1944), 290-93; and *JISMS* 35 (1945), 271-72; "Fuel Rationing and the Physician," *JISMS* 32 (1942), 517-18; "Physicians' Obligation in Gasoline and Tire Rationing," *JISMS* 32 (1942), 554-55; "Invalid Diets and Food Rationing," *JISMS* 33 (1943), 231.



Whatever happened to "Doc's" bedside manner?

They had called Jim "Doc" from his short-pants days, because all his friends and family knew that he planned to follow in the footsteps of his grandfather and favorite uncle—and become a doctor.

But Jim is not a doctor. His medical education has never started, his Bedside Manner has never been tried out. Like so many dreams and ambitions of gentler days, they have been shoved aside by the harsh demands of war.

There are thousands of young men whose medical careers have been pushed years into the future. Every year since the war began, fewer and fewer new doctors have been produced. At the beginning of this year, military requirements cut in half the number of students permitted admission in medical or pre-medical courses.

This is one reason why there not only is a serious doctor shortage now, but why that shortage will last long beyond the firing of the last shot.

There are other reasons. Bringing troops back from all over the world will be a long, difficult task—and their doctors will be among the last to be released. Many doctors will stay abroad to prevent epidemics that might eventually come to us. Doctors who do get back will have much of

their time occupied in caring for casualties of the world's greatest war.

The very best way to save your doctor's time is to make use of his services the minute trouble arises. Never indulge in self-diagnosis. See your doctor early, in time for him to head off more serious trouble. And you can help him further by doing these three things:

Go to him—whenever you are able. House visits take time when someone else may need him urgently.

Keep your appointment promptly; make it at his convenience so that he can plan his crowded hours better.

Follow his advice to the letter—so that your trouble doesn't drag on, get complicated, or need extra attention.

One of a series of messages published as a public service by Wyeth Incorporated, Philadelphia . . . relied upon by your physician and druggist for pharmaceuticals, nutritional products, and biologicals—including penicillin and blood plasma.

HELP YOUR DOCTOR SAVE HIS TIME!



The pharmaceutical company Wyeth took out advertisements to advise the public, because of the shortage of physicians caused by the war, to be conscious of saving their doctor's time, in part by going to the doctor, not relying on the doctor to make house calls. From Journal of the Iowa State Medical Society 35 (March 1945), xxvii.

as “sharply rationed,” even if not officially, as fuel and food were. “John Q. Public” had to refrain from calling at night, except for truly urgent conditions. People had to sacrifice “their convenience to the convenience of the doctor instead of vice versa,” and try to see their physicians during office hours.¹¹⁰ Paul V. McNutt, who chaired the War Manpower Commission, was even more adamant about making medical practice efficient. He told the audience at the American Hospital Association War Conference in the fall of 1942 that “everything possible must be done to make the time of these [civilian] physicians count for the maximum of service to patients.” “Every half hour of professional service,” he continued, “must now do an hour’s work.” To compress an hour into 30 minutes, routine tasks had to be delegated to nurses and assistants; hospitals had to expand outpatient clinics, so that physicians could reduce home visiting. At the same time, hospitals and physicians themselves had to adapt to shortages in equipment and supplies. “You have to face the paradox of producing more and more service with less and less equipment. You have to make old equipment do,” McNutt stated flatly.¹¹¹

Civilians, including physicians, demonstrated their patriotism by facing long hours of work and limited resources with cheerfulness, or at least not too much overt grumbling. But a number of Iowa physicians found their patriotic sensibilities stretched to the limit when Congress passed an act in March 1943 to establish the Emergency Maternity and Infant Care Program (EMIC) for the wives and infants of enlisted men in grades four through seven of the U.S. Army, Navy, Marine Corps, and Coast Guard. The act allocated \$4.4 million for the Children’s Bureau (under the Department of Labor) to distribute in fiscal year 1943–44 to states that accepted its provisions. Administered through states’ departments of health, the program covered all wives and infants of low-ranking servicemen through pregnancy, childbirth, six weeks of maternal postnatal care, and

110. “It Would Help . . . !” *JISMS* 32 (1942), 461. This was such a popular editorial that the ISMS Board of Trustees had to approve filling doctors’ requests for reprints: “Meeting of the Board of Trustees, Friday, October 2, 1942,” *JISMS* 32 (1942), 518.

111. Paul V. McNutt, “‘Upgrading’ of Medical Services,” *JISMS* 32 (1942), 563.

the first year of the child's life.¹¹² There was to be no means test; this was not charity. The Children's Bureau determined a nationwide fee schedule for doctors' services and hospital charges. To participate in the service, women had to accept "ward service" for themselves and their infants, and doctors had to agree that "supplementary payment from the family must not be accepted," even if patients were "able and willing to pay" the difference between the specified maximum fees and the doctors' normal charges. Payments for care were sent directly to the physician, moreover, which brought the dreaded "third party [that is, the government] between the physician and his patient." In April 1943 the ISMS Maternal and Child Health Committee advised "that there was no alternative but to cooperate in the program," as the federal government had already widely publicized it. By December, after the program had started in Iowa and the Children's Bureau had refused to make changes that "practicing physicians" had pleaded for, the ISMS Maternal and Child Health Committee made it clear that "continued cooperation is based solely upon patriotic grounds and a desire on the part of the medical profession to take no action which would in any way impede the war effort."¹¹³

Physicians did not have to participate in the program. "But few physicians wish to be placed in the embarrassing position

112. [Supplemental Report from the Committee on Maternal and Child Health]," *JISMS* 33 (1943), 336. The Children's Bureau had had modest funds to distribute for this purpose in 1942, for which Iowa's Department of Health had applied, only to have the Children's Bureau reject its plan to allocate equal amounts to all of Iowa's counties (\$100 each). After negotiations with the Children's Bureau, the funding was granted to the State Department of Child Health to pay for obstetric and pediatric care at the UI Hospitals. See Harold E. Farnsworth, "[Report of the] Committee on Maternal and Child Health," *JISMS* 33 (1943), 327; "Plan for Obstetric Care at the University Hospitals for Selected Cases," *JISMS* 33 (1943), 61.

113. "Emergency Maternity and Infant Care Program," *JISMS* 33 (1943), 476-77; Everett D. Plass, "The Physician's Attitude Toward the Emergency Maternity and Infant Care (EMIC) Program," *JAMA* 127 (1945), 102-3; "The EMIC Program and the Children's Bureau," *JISMS* 34 (1944), 405; "A Further Word on the EMIC Program," *JISMS* 34 (1944), 22; "Report of the Committee on Maternal and Child Health," *JISMS* 34 (1944), 297. Given the lack of comment on the EMIC program in the major histories about the defeat of national health plans, it is likely that EMIC is an underappreciated source of physicians' attitudes during the 1940s. See Gordon, *Dead on Arrival*, 131-32, 139.

of refusing their services to the wives and infants of our countrymen," an editorial in the *ISMS Journal* pointed out. Embarrassed or not, Dr. Arthur D. Woods, a physician from Marshall County, reported to the 1944 ISMS annual meeting that members of his county society had "unanimously rejected the plan. . . . We are taking care of the women, and, if we have to, we will do it for nothing." "This is an extremely hot baby," Dr. Lee Roy Woodward of Mason City—and ISMS president that year—remarked as a lively discussion opened among the members of the society's House of Delegates. Enlisted men's wives and infants needed medical care, and no one disputed the worthy intent of the plan. And, Dr. Suchomel reminded his colleagues, if ISMS physicians refused to participate, osteopathic physicians would have a "golden opportunity of publicizing the fact" and would be more than happy to take on these patients. Dr. C. P. McHugh warned his fellow delegates that they would only alienate soldiers and sailors. "When a fellow comes out from some jungle in which he has been for weeks and weeks and says, 'Some doctor wouldn't take care of my wife in Marshalltown because they would only give him \$35.00,' he is going to be mad, and every man in his company is going to be mad." In the end, the delegates passed a resolution protesting the Children's Bureau's "regimentation" of medical care, and decided to send two representatives to Washington, D.C., to register their complaints with Iowa congressmen and to testify before an upcoming House Appropriations Committee hearing.¹¹⁴

Dr. Everett Plass, a nationally known professor of obstetrics and gynecology at the UI College of Medicine, and Dr. Ransom Bernard of Clarion, a general practitioner with a specialty interest in surgery, went to Washington for the April 27 appropriations hearing. Nothing changed. Congress approved a \$42.8 million appropriation to EMIC for 1944–45 and refused to consider a different payment method. "The government's position seemed to be that it was acting in favor of the doctors, because if the subsidy were to be paid directly to the serviceman's wife she might spend it for something else and the physician would not get paid at all." The Children's Bureau adamantly upheld

114. "Transactions of the House of Delegates," *JISMS* 34 (1944), 307–11, 316–18.

its payment system, moreover, because it did not want any serviceman's wife to have "to bargain with either the hospital or the physician over the fee she was to pay. This it was claimed would defeat the whole purpose of the program, which is to provide obstetric and infant care absolutely free."¹¹⁵

In an essay published in the *Journal of the American Medical Association* early in 1945, Dr. Plass zeroed in on what he saw as the "fundamental issues" at stake in the EMIC program. These were not just the problems that physicians had already raised, which he reiterated, but encroachment of the federal government directly into providing medical care. "It cannot be denied that sentiment for compulsory federalized health insurance is strong among our legislators." The Wagner-Murray-Dingell bill, first introduced in 1943, which promised a sweeping national health system, was about to be brought before Congress again. The EMIC, Dr. Plass and others observed, pointed to how such a system might actually operate—its expense, the "vast amount of clerical and bookkeeping work," and the "onerous form of regimentation" that came with imposing a "countrywide financial standard" on both physicians and patients.¹¹⁶

For Dr. Plass, the EMIC plan had also highlighted "the split personality of the medical profession." Many physicians did want to make money, sometimes at the expense of their ideals. "The same monetary urge has made the physician oppose the EMIC program violently in his society meetings, even while he is accepting as many patients as come to him for care under its provision," Dr. Plass wrote. When the Children's Bureau raised the maximum fee for "complete obstetric care" from \$35 to \$50, it knew what it was doing, Dr. Plass argued. Making "minor financial concessions to pacify the majority of medical men" diffused the political will of organized medicine.

115. "The EMIC Program and the Children's Bureau," *JISMS* 34 (1944), 405-6.

116. Plass, "The Physician's Attitude Toward EMIC," 102, 104; Starr, *Social Transformation*, 277-84; "Wagner-Murray-Dingell Bill," *JISMS* 33 (1943), 560-61; "Wagner-Murray-Dingell Bill Introduced in Congress," *JISMS* 35 (1945), 262. Dr. Plass originally gave his paper at the Annual Conference of Secretaries and Editors in Chicago in November 1944. The *JAMA* printed the discussion that followed. See especially the comments from Dr. Thurman Rice of Indianapolis, p. 105.

As critical as he was of EMIC, Dr. Plass recognized that simply complaining would not accomplish much. "Without offering another plan which will resolve the admitted inequalities of the present system of medical practice, we brand ourselves as non-progressive reactionaries and still further lower ourselves in the eyes of the public."¹¹⁷ He offered no suggestions at that point, but opinions like Dr. Plass's undoubtedly fueled the push for physician-controlled voluntary insurance plans under way in Iowa and elsewhere as the war drew to a close. Certainly the Children's Bureau's efforts to continue funding maternity and infant medical care after the "emergency" of war had passed faced physicians' "resentment and antagonism" at having had their viewpoints ignored. Even the Executive Board of the American Academy of Pediatrics, long a staunch supporter of Children's Bureau's programs, had decided in 1944 to "publicly announce withdrawal" of their support for the Bureau after the war ended, given the evidence that the Bureau planned to "directly invade the field of private practice of medicine."¹¹⁸

The defeat of bills for a comprehensive national health system during the war and in the immediate postwar period rested on a great deal more than physicians' irritation with the heavy-handedness of the Children's Bureau, of course. The reactions of Iowa's doctors—both academic specialists such as Dr. Plass and small-town general practitioners such as Dr. Woods—nevertheless reveal another layer of doctors' frustration with "government" medicine, and so help to convey why many of them opposed it so staunchly despite their concerns about real inequities in American health care.

Federal involvement with medical institutions and practice continued to expand after the war, however. Elements of the Wagner-Murray-Dingell vision that appeared in separate bills passed Congress between 1945 and 1950, largely because they had the support of organized medicine. The Hill-Burton Act of 1946 (the Hospital Survey and Construction Act), for example,

117. Plass, "The Physician's Attitude Toward EMIC," 105.

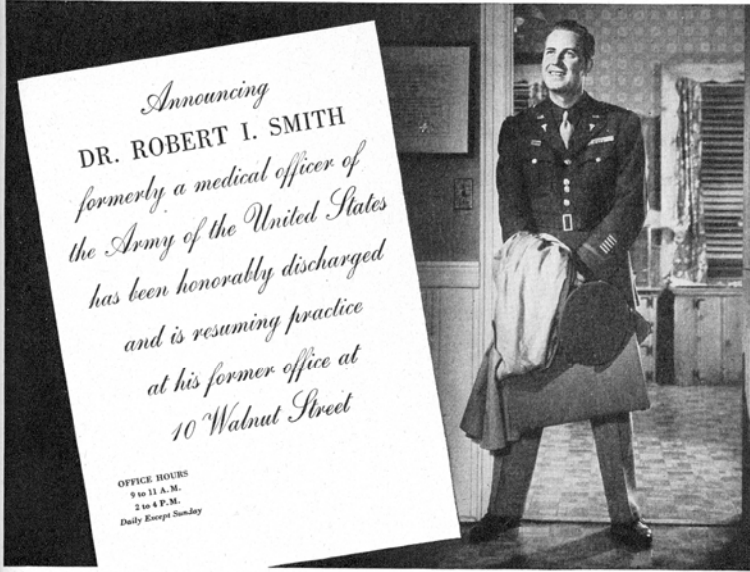
118. "The EMIC Program and the Children's Bureau," *JISMS* 34 (1944), 405-6; "Next Steps Proposed for the Children's Bureau by the National Commission on Children in Wartime," *JISMS* 35 (1945), 332-33; "Defeat or Modification of S. 1318 Imperative," *JISMS* 35 (1945), 439.

provided funds for determining areas where hospitals were most needed, and grants-in-aid to states for one-third of the cost of constructing facilities in high-priority areas. By February 1950, 31 plans for new or expanded hospitals in Iowa were under way, at a cost of nearly \$19 million.¹¹⁹ The importance of tax-funded investment in medical research, which had gained new urgency at the federal level during the war, transformed the National Institutes of Health under generous appropriations from Congress; in 1947, the NIH received \$4 million for in-house and extramural research, compared with \$180,000 in 1945. Other agencies, such as the U.S. Public Health Service and the U.S. Atomic Energy Commission, also had increased budgets for funding medical research at universities, including the University of Iowa. The GI Bill, which applied to returning military physicians seeking additional training, along with determined AMA efforts to orchestrate enough residencies to fill their demands, turned political thoughts to devising a federal grant program to support medical education, resulting in much-debated bills introduced in Congress in 1949 and 1950.¹²⁰

The war and the political fervor for a national health care system also pushed practitioners towards specialization. Dr. George Wilkinson, who received his University of Iowa M.D. in 1941, reminded his audience at the ISMS meeting in 1948 of the military facts of life. "In the army it became evident that specialized training was of paramount importance. Formalized residency training and board certification were the primary deciding factors which obtained the pleasant and interesting hospital

119. "Hospital Construction in Iowa," *JISMS* 36 (1946), 494-95; Boice, "Hospitals in Iowa," 417-19.

120. Starr, *Social Transformation*, 338-51; E. M. MacEwen, "Medicine and Medical Education in the Postwar Era," *JISMS* 35 (1945), 355-56; "Hospital Residencies for Returning Veterans," *JISMS* 35 (1945), 440-41; "Hospital Survey and Construction Program," *JISMS* 36 (1946), 551; "Hospital Survey and Construction Program," *JISMS* 39 (1949), 22-23; "Federal Aid to Medical Education," *JISMS* 40 (1950), 33-34. For an example of a U.S. Atomic Energy Commission grant to fund medical research at the UI, see "Personals," *JISMS* 40 (1950), 242: "Dr. Titus C. Evans, director of the SUI radiation research laboratory, and Dr. Paul J. Leinfelder, professor of ophthalmology, will conduct one of 34 new research projects in biology and medicine in the Atomic Energy Commission program. They will study the effects of x-ray and neutrons on producing lens damage to the eye."



Welcome Home, Doctor!

Warriors Without Weapons . . . Soldiers in White . . . Marshals of Mercy . . .

The medical men in the war will be the subject of novels, plays, and movies for years to come. But words, pictures . . . statistics, revealing as they are . . . won't begin to tell the whole story of the magnificent work you did. Nor will words be adequate to express fully the appreciation and thanks of your fellow men.

The makers of Camel cigarettes join with millions of others in saying, "Well done, Doctor" and "Welcome home!"

CAMELS *Castler*
Tobaccos



R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

R. J. Reynolds Tobacco Company took out a full-page advertisement in the Journal of the Iowa State Medical Society to thank doctors for their service during the war and to welcome them home. From Journal of the Iowa State Medical Society 35 (December 1945), xix.

assignments." After the war, he returned to do a surgical residency: "it was distasteful that I should relegate myself to the roll [*sic*] of pimping for the specialist." Dr. Wilkinson noted that he particularly feared "the limitations and restrictions which board men, certified specialists, and medical politicians would attempt to clamp on me" if he did not follow the prescribed path. He ultimately decided, nevertheless, that he really wanted a general practice, and left the residency to open an office in Burlington. Some physicians leaving service assumed that if "socialized medicine" came to the United States they would be classified as they had been in the military, with salaries linked to specialty experience and certification, "and many of them resolved to secure these advantages when they returned home."¹²¹

The attraction of specialty practice for veterans and new graduates sparked concern over the probable demise of the general practitioner, which joined the dismay of earlier decades over the apparent passing of the rural doctor. In 1949 Dr. Michael Carey, a middle-aged general practitioner in Council Bluffs, wrote bluntly that "today, to be a general practitioner seems to carry a stigma of inferiority." He urged his colleagues to support efforts to heighten professional respect for their work because, he asserted, patients preferred general practitioners, who were "willing to listen to their ailments . . . and treat their bodies as a whole, not piecemeal," rather than "be bandied about from one specialist to another." For Dr. Carey, specialists threatened not only "the intimate doctor-patient relationship, so necessary to private practice," but also general practitioners' autonomy. Ever increasing restrictions on what the general practitioner could do in the hospital—being told one day, for example, that "such-and-such procedures may be done only by a certified specialist" after having done them for years—pointed to a future that Dr. Carey did not welcome. The "rules and regulations fostered and inspired by apparently well-meaning [national] board members" heralded the way that the medical profession itself was moving toward setting national standards for practice

121. George W. Wilkinson, "Why I Chose General Practice," *JISMS* 38 (1948), 285–87; William A. O'Brien, "Recent Developments in Hospital Organization and Medical Practice that May Affect the Future," *JISMS* 36 (1946), 279.

in the postwar decades.¹²² The diverging paths of generalists and specialists, heightened by the expanding role that medical research had within medical schools and university hospitals, came into focus in these postwar years, and they would reshape the meaning of “physician control” for the rest of the century.

Conclusion

“Physician control,” the mantra so regularly voiced during meetings of the Iowa State Medical Society and published in the *Journal’s* editorials and articles, spurred the expansion of organized medicine between 1929 and 1950. It provided a common ground for resistance to outside groups—especially government agencies—that hoped to control private, fee-for-service medical practice or, more radically, to replace it with some other system that could bring affordable health care to all Americans. As much as some Iowa physicians may have disliked the American Medical Association, when it came to dealing with perceived threats to their professional autonomy, the county medical society became the local unit for professional solidarity, and the state medical society the place to work for political goals.

The experiences and reactions of Iowa physicians in the 1930s thus highlight not only the increasing pressures on them to find some solutions for the burdens of high medical costs, but also the complexities of their responses to those demands when faced with the changes that pre-payment plans might make to the way they practiced medicine. As important as considerations of income clearly were for AMA leaders and rural physicians alike, Iowa physicians at all levels saw state and federal involvement in payment programs as threatening several profoundly held values that meant as much as—or more than—money. A decade of experience with trying to care for indigent patients during the Depression deeply undermined the physician’s traditional methods of managing poverty: the sliding scale, personal charity, and a firm belief that the poor should have free choice of physician, who would then provide the best

122. Michael J. Carey, “The General Practitioner in This Era of Specialization,” *JISMS* 39 (1949), 110, 111.

medical treatment without regard for remuneration. As unpleasant as the individual physician's paternalism may have been for patients unable to pay, or as deficient as that care may actually have been for those stigmatized by pauperism, practitioners took considerable pride in their idealistic values in the midst of their own economic distress. As long as physicians felt that their generosity was largely voluntary and appreciated, then they could be proud of it. When it was expected and imposed by lay people, whether businessmen or social workers, they felt undermined, exploited, and dependent on others' estimation of the value of their work.

During the 1930s Iowa physicians of all sorts gained direct experience with "government" medicine when managing care for the indigent and poor in their counties. Where county medical societies negotiated with boards of supervisors for care of the indigent, moreover, Iowa physicians had to balance their individual autonomy with the collective good of the physicians who shared that duty. However much physicians may have talked about collective interests and proclaimed professional ideals in their meetings, the abstract became quite concrete at that point. The work had to be done and fair bills submitted, sometimes even reviewed by their own colleagues. The county supervisors and relief agents in charge of state and federal allocations scrutinized hospital costs and physicians' charges as well, and brought external monitoring of medical costs to a new bureaucratic level.

In the 1940s the Emergency Maternity and Infant Care program provided another experience of "government" medicine. The purpose was admirable, for doctors had long advocated the importance of prenatal and infant care for reducing maternal and infant morbidity and mortality. In its execution, however, physicians felt manipulated into accepting a nationally standardized program in which their points of view were trivialized and ignored. That experience made even the most patriotic of Iowa doctors bitter.

Physicians' reluctant turn toward voluntary, non-profit hospital and medical insurance in Iowa was born of political necessity. The Iowa Hospital Association (Blue Cross) and Iowa Medical Service (Blue Shield) plans were "physician controlled" in

the sense that leaders of the ISMS appointed physicians to the boards of these non-profit corporations, and those physicians had some influence on the plans' scope and principles. Professional managers and insurance experts also had a great deal of weight in how these businesses operated, however. In 1948–49, when hospital costs under Blue Cross in Iowa had risen faster than its managers expected, analysis pointed to “possible abuse” in admission for diagnostic purposes and in the ordering of expensive laboratory services, drugs, oxygen, and physical therapy. “It is felt that the physician must have the moral fortitude to tell his patient he is not entitled to diagnostic services under his contract,” an editorial in the *ISMS Journal* told its readers. And, it went on, doctors simply had to keep costs down or voluntary insurance plans — *their* plans — would fail.¹²³

In the midst of confusion and frustration over professional issues, physicians did have a major solace in the late 1940s. What they could do for their patients expanded every year. Antibiotics cured people rapidly sinking towards death. Prompt whole blood transfusions enabled others to survive trauma and operations that would have been nearly impossible before. Soon, other new drugs and techniques were announced so frequently that rapid change itself became the new status quo. As federal funds began to flow to Iowa for advanced laboratory and clinical investigations, moreover, Iowa-based physicians and scientists began to make their marks in national and international circles for their research results. Over the next 50 years, heartfelt celebrations of biomedicine's efficacy and triumphs regularly appeared alongside continuing criticisms of the profession's inability to figure out how to bring affordable, high-quality, empathetic health care to all people. Iowans, like many Americans, had learned to want it all.

123. “High Utilization Experience of Blue Cross,” *JISMS* 39 (1949), 399.