UC Berkeley
The Charles H. Percy Undergraduate Grant for Public Affairs Research Papers

Title
How Doctors Organize: Applying Theories of Collective Action to Modern Organized Medicine

Permalink
https://escholarship.org/uc/item/49b7x141

Author
Ullal, Aditya

Publication Date
2011-05-31

Undergraduate

eScholarship.org Powered by the California Digital Library
University of California

How Doctors Organize:
Applying Theories of Collective Action to Modern Organized Medicine

A Thesis Presented to

The Faculty of the Political Science Honors Program

in partial fulfillment of the requirements

for a degree with honors

of Bachelor of Arts

by

Aditya Ullal

University of California, Berkeley

May 2011

ABSTRACT

Background: Decades after Paul Starr (1982) wrote his Pulitzer Prize winner *The Social Transformation of Medicine,* there appear to be two narratives on how doctors have politically organized. One story describes the powerful American Medical Association that led American physicians to dominance in medicine. The other, more recent story has featured the rise of numerous other organizations created in the wake of medical specialization and each lobby on their own.

Objective: In response to the limited knowledge on modern "organized medicine", I investigate the basis for physician political organization by applying seminal works of collective action to modern organized medicine. I ask "how do groups within organized medicine approach the collective action problem as they lobby?"

Methods: Examining 81 organizations that represented physicians on health issues from 2006 through 2010 at the national level, I show the most recent political behavior of organized medicine through data obtained from financial statements, organization websites, and lobbying disclosures. The contribution of this paper is primarily descriptive.

Conclusions: Groups within organized medicine tend to lobby as a by-product, not as a primary goal. The behavior of these organizations follows closely in the tradition of classic political science literature, suggesting that political representation for physicians comes from groups largely focused on professional advancement goals for its members instead of a more exclusive focus on healthcare policy.

Table of Contents

Acknowledgements i

1 **Introduction** **1**

Politics and the Doctor 2

The Collective Action Problem Identified 4

The Value of Studying Collective Action in Organized Medicine 5

Research Question and Thesis Structure 7

Main Arguments 8

2 **Theories on Collective Action** **9**

Olson: "Material Incentives and Lobbying as a Byproduct" 9

Clark and Wilson: "A Theory of Incentive Systems" 12

Walker: "Modern Interest Groups with Outside Funding" 13

Testing the Theories Presented 14

3 **An Overview of Politics for American Physicians** **15**

Physicians Led By the AMA 15

Incentive Theory in the Old Paradigm of Organized Medicine 17

Important Developments Where Organized Medicine Literature Leaves Off 19

Moving On: Modern Healthcare Politics for Doctors 21

Specialist Dominated Medicine 23

Chapter Recap 25

4 **Inclusion Criteria and a Profile of Organized Medicine** **26**

Methods: Inclusion Criteria for Organizations in This Thesis 26

A Brief Profile of Organized Medicine: 2006 Through 2010 28

Organized Medicine in the Larger Health Policy Domain 30

Chapter Recap 31

5 **Incentive Systems in Organized Medicine** **32**

Theories Reexamined 33

Chapter Methods 34

Material Incentives in Organized Medicine 35

Organization Age and Variation in Material Benefits 38

Organization Size and Variation in Material Benefits ... 40
Does Intra-Specialty Competition Spur More Incentives? ... 41
Solidary Incentives in Organized Medicine ... 42
Organization Age and Variation in Solidary Benefits ... 43
Organization Size and Variation in Solidary Benefits ... 45
Intra-Specialty Competition and Variation in Solidary Benefits ... 46
Alternative Conceptions of Solidary Benefits ... 46
Purposive Incentives in Organized Medicine ... 47
Organization Age and Variation in Purposive Benefits ... 48
Organization Size and Variation in Purposive Benefits ... 50
Intra-Specialty Competition and Variation in Purposive Benefits ... 51
Chapter Recap ... 51

6 Organized Medicine by the Numbers ... 53
Chapter Methods ... 53
Examining Sources of Revenue within Organized Medicine ... 53
Member Dues and Services in Revenue Creation ... 54
Walker's Outside Sources of Funding ... 56
Cause for Concern? ... 57
Examining Organizational Expenditures and the Role of Lobbying ... 59
Walker's Outside Funding Revisited ... 61
Chapter Recap ... 64

7 Conclusion ... 65
Concluding Thoughts on Fractionated Politics ... 65
Drastic Decline of the AMA? Thoughts on the Future of Physician Organization ... 66
Relevance to Medical Care and the Healthcare System ... 68
Study Limitations ... 70
Future Topics for Research ... 71

Appendix ... 73
References ... 83

Tables and Figures

Figure 3-1. *Federal Lobbying Expenditures by Sector*................................ 22

Figure 3-2. *Percentage of Third-Year Internal Medical Residents Choosing Careers*

.... 23

Table 4-1. *Organized Medicine by Age*.. 28

Figure 4-1. *Organizational Density of Groups Within Organized Medicine*

.... 29

Figure 4-2. *Lobbying Expenditure by Organized Medicine*..................... 30

Table 4-2. *Lobbying Expenditures by Organized Medicine*..................... 30

Figure 4-3. *Y*EARS 2006-2010: Sources of Healthcare Lobbying Expenditure

.... 31

Figure 5-1. *Top 10 Selective Material Incentives*.. 36

Figure 5-2. *Organization Age and Material Incentives*............................. 39

Figure 5-3. *Organization Size and Material Incentives*............................ 41

Figure 5-4. *Number of State and Local Chapters Offered*......................... 42

Figure 5-5. *Organization Age and Chapters Offered*................................. 44

Figure 5-6. *Organization Size and Chapters Offered*................................. 45

Table 5-1. *Other Types of Solidary Benefits*... 46

Figure 5-7. *Number of Purposive Issues (Average)*..................................... 48

Figure 5-8. *Organization Age and Purposive Issues*................................... 49

Figure 5-9. *Organization Size and Purposive Issues*................................... 50

Figure 6-1. *Member Dues in Revenue Generation*...................................... 54

Figure 6-2. *Member Dues + Program Services in Revenue Generation* 55

Figure 6-3. *Percent of Functional Revenues from Sources Outside Member Dues and Fees* 56

Figure 6-4. *Sources of Outside Funding in Organized Medicine*........ 58

Figure 6-5. *Functional Expenses in Lobbying*........ 59

Figure 6-6. *Program Services as a Percentage of Functional Expenses* 60

Figure 6-7. *Outside Funding vs. Benefits Given* 62

Figure 6-8. *Relationship Between Outside Funding and Lobbying* 63

ACKNOWLEDGEMENTS

While working towards this thesis for a year, I have learned many things about healthcare and healthcare politics. But the biggest thing I learned was that it takes the help of many wonderful people to finish a thesis.

I would like to thank my advisors Professors Rob Van Houweling and Terri Bimes, whose tireless patience and advice helped me through the toughest parts of this thesis. They have both proven excellent mentors who pushed me towards this final product, and for that I am incredibly grateful.

I would also like to thank Professors John Elwood and Eric Schickler whose advice was critical in the beginning stages of choosing a topic.

Thanks go also to Rex de Guia: a boss, a friend, and a mentor who encouraged me to find opportunities to mend my interests from my two very different majors of Political Science and Molecular & Cell Biology. This thesis proved to be one outlet for this.

Additionally, I must thank my mother without whom could not have completed this thesis. Her constant encouragement and unfailing reliability have never changed over the years, and she was immediately there when I needed help on many late nights and long days from December to April. Without her, I would never have finished the coding and running of numbers needed to finish this thesis.

Last but certainly not least, I would like to thank the Brandt family who made the Percy Undergraduate Grant for Public Policy available to students like me. Through their generosity, I was able to access a program called Guidestar that was critical for collecting the data presented in Chapter 6.

Chapter 1: Introduction

In this thesis, I shed light on organizations which represent American physicians at the federal level. I ask, "How do groups within organized medicine approach the collective action problem as they lobby?" The following chapter introduces a general gap in knowledge on physician political organization, describes the value proposition of this research, and elaborates on the overall research question with a roadmap for remaining chapters in this thesis. To conclude this chapter, I emphasize the main argument which I ask the reader to keep in mind throughout this thesis.

The year was 1965 and the government sought passage of a historic piece of legislation to expand health coverage for American seniors. As the legislation flittered back and forth through the halls of Congress for final revisions, there was still one force that presented an obstacle to the program. Under the banner of the American Medical Association, physicians had a formidable political machine with far reach across the fifty states. With anticompetitive practices of boycotting insurers, these physicians could have doomed the Medicare program altogether.

Johnson knew he needed the buy-in of doctors in order for success, and though he might not convince them of the merits of government involvement in healthcare, he did have a few tricks up his sleeve (Blumenthal and Morone 2009).

On July 29, 1965, the same day that Senate voted to approve Medicare legislation, Johnson met with AMA President James Appel and was prepared to give him "the full Lyndon". First, Johnson spoke at length about his appreciation for doctors and his firsthand experiences with physicians while his father was ill. Then he shifted the conversation to Vietnam and the

medical needs of the Vietnamese people. Perhaps Americans physicians could help in some way, he thought aloud. Appel, relieved to find a topic of agreement, suggested that the AMA would start a program and send doctors abroad to help (Blumenthal and Morone 2009).

With that, Johnson leapt to his feet and called his secretary to let the media into this private meeting. The seemingly grateful President then sang praise of the selflessness of American doctors, all the while knowing that the media would move on to more controversial topics. The press was quick to catch on and soon brushed aside talk of Vietnam. They asked Appel directly: would American doctors support a Medicare program?

With that last question, Johnson indignantly offered, "These men are going to get doctors to go to Vietnam where they might be killed…. Medicare is the law of the land. Of course, they'll support the law of the land." Turning to Appel, he added, "You tell him" (Blumenthal and Morone 2009, 199).

Clearly caught off guard, the AMA President mustered a meek response. "Yes," he replied. "We are, after all, law abiding citizens."

This was the memorable story of how President Lyndon Johnson tricked a flustered AMA President into declaring public support for Medicare.

Politics and the Doctor

As the story of LBJ and Medicare might suggest, doctors played a tremendously influential role within American healthcare and could have easily undermined the Medicare program without the political maneuvering of the President (Starr 1982). But, of course, their power extended beyond this one government program.

Political Scientist Jacob Hacker argues that much of the American healthcare system we see today results from political decisions made by physicians throughout the 20th century (Hacker 2008). Through the AMA, politically organized doctors pre-determined fees for health services, controlled hospital accreditation, and completely revamped medical school curriculum (Stevens 1998). They gained tight control of the number of practitioners within the physician workforce and influenced insurance policy as they sat on the payment boards for Blue Cross/Blue Shield at mid century (Delbanco, Meyers, and Segal 1979; Laugeson and Rice 2003; Kessel 1958). They wielded enormous coercive sanctions such as the withholding of malpractice insurance, prevention of patient referrals, and denial of hospital admitting privileges for physicians that failed to follow AMA guidelines (Kessel 1958). And perhaps most memorably, organized medicine played a notorious leadership role in powerful anti-reform coalitions with big business and American unions who likewise sought to derail national health insurance (NHI) during the early half of the century (Stevens 1998, 59-60; Peterson 1993; Hacker and Skocpol 1997, 319).

In more recent literature however, scholars compare this traditional conception of a unified organized medicine led by the AMA with more recent observations of schisms in physician organization (Peterson 1993; Laugeson and Rice 2003; Quadagno 2004; Stevens 2001). As more doctors specialize within medicine, they now join any one of the numerous specialty societies across the country that best represents their practice (Baumgartner and Talbert 1991; Peterson 1993; Stevens 2001). A major implication for this new age for healthcare politics is that it may no longer be adequate to mention the American Medical Association as the sole source of representation for American physicians on policy matters.

While works in political science, sociology, and history comprehensively chronicle political gains of organized medicine up to the 1980s, research on politically organized doctors is relatively scant after this time period[1] (Stevens 2001). This makes it difficult to assess the political consequences for physicians as an increasing number of organizations have splintered off of the 20th century physician political movement in order to lobby on their own (See Stevens 1991; 2001; Landers and Sehgal 2000; 2004). As a starting point to assess the current state of organized medicine, I offer this thesis as research that explores collective action problem and how it applies to the numerous organizations that now represent American physicians today.

The Collective Action Problem Identified

Before collective action problem was first recognized, most political scientists and sociologists followed the logic of pluralists like David Truman. In *The Governmental Process,* Truman posited that the formation of "pressure groups" is a natural phenomenon partly grounded in a human proclivity towards interaction (Truman 1951). He believed that the role of pressure groups was to channel the collective contribution of members towards seeking policy change that better reflects member needs. Pluralist theory correctly predicted that societal advancement leads to specialization of tasks and labor, just as we see within medicine. Pluralist theory additionally predicts that specialization causes proliferation of new groups pursuing policy goals, which once again is in line with the pattern in organized medicine. While prescient in these respects, Truman's pluralist theory is still imperfect because it implies that all members join groups for political reasons.

---

[1] See Garceau (1941), Harris (1966), Rayack (1967), Hirschfield (1970), Marmor (1973), Burrow (1977), Feldstein (1977), Numbers (1978), Poen (1979), Starr (1982)

Over time within political science, we now have a different perspective on member contributions and the need to join interest groups. Starting with the work of economist and social scientist Mancur Olson in *The Logic of Collective Action,* it became widely accepted that individuals do not naturally join groups that seek to represent them. In fact, Olson (1965) argues that individuals would work against their rational self-interests by joining a group when they could easily enjoy benefits attained by that group without working towards the cause. In describing this "free-rider problem", Olson suggests that rational individuals only contribute to an interest group when the incentives for joining are high enough to offset the costs intrinsic to membership, such as time or money.

This collective action problem is particularly inherent in lobbying. Because groups that lobby usually seek collective goods which are benefits that cannot be barred from non-members, there is little incentive for individuals to join the group. For example, if the AMA were to win increased pay on behalf of physicians through successful lobbying, this benefit can be enjoyed by physicians across the country irrespective of their membership to the organization. Therefore, why would any physician logically join the AMA? This hypothetical example demonstrates the basic problem of collective action faced by groups that lobby. In this thesis, I explore how organizations that represent physicians approach the problem.

The Value of Studying Collective Action in Organized Medicine

What is the overall value in this research? The answer comes threefold. First, examining organized medicine through the framework of collective action gives particular insights into the underlying incentives behind physician political organization. In this thesis, I provide a new look at the types of associations that historically dominated healthcare politics for much of the 20th

century as well as newer organizations whose lobbying behavior has not yet been described. As Americans are consumers of health services, there should be more emphasis on elucidating the patterns of physician political organization, especially in a healthcare system where physicians control “vast sums of other people’s money” with every health decision (Mechanic 1991, 487).

Second, studying the incentives in-built in organized medicine will be relevant to such critical topics as healthcare costs, quality, and perhaps reform. For example in the 1980s, Congress fundamentally misunderstood these same professional societies and believed that they would aide cost-containment within Medicare (Laugeson 2009). Understanding the impetus for physician political organization may also clarify the role physicians will have in the public sphere as government becomes increasingly involved in healthcare. After all, doctors have unique technical expertise and scientific backing to make important suggestions towards public health objectives (Wilkerson and Carrell 1999, 337). And while by no means selfless in this effort, doctors also serve as a countervailing force to improve healthcare quality by fighting back against the perceived excesses of managed care organizations and private insurance companies that focus on the bottom line of costs (Light 1991; Mechanic 1991; Mechanic 2001).

A final benefit of studying organized medicine through a collective action framework may be greater understanding of the political impacts of medical specialization. In particular, we are interested in the consequences of fractionated politics as lobbying efforts on behalf of physicians are now divided amongst numerous groups unlike before. This research clarifies the more general lobbying of the newer organizations in age of interest group proliferation. And at the bottom of this are findings which speak to the broader applicability of existing collective action theories within segments of business and industry such as in healthcare.

Research Question and Thesis Structure

Towards redressing the lack of understanding on modern organized medicine, this thesis provides an updated profile on physician associations by observing those which lobbied during the five-year period from 2006 through 2010. With limitations in data notwithstanding, I find that there are now a total of 81 organizations within organized medicine that reported lobbying expenditures at the federal level during this time frame[2]. Through the course of the next six chapters, I provide a descriptive analysis that provides insight into these organizations by answering the research question: "How do groups within organized medicine approach the collective action problem as they lobby?"

As I look for an answer, I draw upon seminal works on collective action and test their applicability to these 81 organizations. Olson's (1965) "By-Product Theory" suggests that interest groups organize largely on the basis of selective material benefits and that the lobbying presence of organizations is merely secondary to other functions of a group. The "Theory of Incentive Systems" by Clark and Wilson takes Olson's material incentives and argues that interest groups distribute two additional categories of incentives to individuals "in order to induce them to contribute activity" (Clark and Wilson 1961, 1). Finally, Jack Walker responds directly to these incentive theorists by arguing that modern interest groups do not need to focus as much on incentivizing membership when they can rely outside sources of funding to carry out their policy objectives (Walker 1983; Walker 1991; King and Walker 1992). Any one of these theories may explain how organized medicine approaches the collective action problem.

As I answer the overarching research question, I follow a specific roadmap within this text. After this section, Chapter 2 introduces the theories on collective action in greater depth and detail, describing how they will be tested in this thesis. Chapter 3 provides an overview of

[2] More on how these organizations were chosen within the Methods section of Chapter 4

physician political organization from past to present as a context behind the topic. Next, Chapter 4 introduces the inclusion criteria used to find the 81 organizations and provides an updated profile of organized medicine as a precursor to data chapters. Chapter 5 subsequently focuses on the incentive systems involved in physician associations and medical societies by describing the benefits offered by these 81 groups to incentivize membership. Chapter 6 follows this with an analysis of the financial data of these organizations to reveal the merits of theories regarding lobbying and outside funding in these groups. Finally, Chapter 7 offers a conclusion with an account of the major limitations and potential topics for future research.

Main Arguments

While consequent chapters elaborate upon specific findings, I ask the reader to bear in mind the main arguments of this thesis. By the end of this thesis, I argue that the organizations within organized medicine may not be as politically-oriented as previously believed, and that they lobby as a byproduct of other professional and scientific goals that members have. I find specifically, that these organizations rely heavily upon material incentives which provide direct economic or monetary return for members, and that while no single theory entirely describes organized medicine, all have some element of applicability to the organizations I study.

With the findings I present, I suggest that there should be a fundamental re-examination of organized medicine both within the medical community and within the political science literature which views them as more traditional interest groups.

Chapter 2: Theories on Collective Action

This chapter refers to three notable theories in political science to explain how groups within organized medicine may approach the collective action problem. This chapter concludes with an explanation on how these theories will be tested in following chapters.

In Chapter 1, I identified Olson's collective action problem as it pertains to lobbying. In summary, this framework assumes individuals to be rational, self-interested actors who would not join interest groups when they could just as easily enjoy collective goods without accruing the costs of membership. Organizations may have a number of ways to approach this problem, and perhaps the best place to begin is with the theories of Olson himself.

Olson: "Material Incentives and Lobbying as a Byproduct"

In *The Logic of Collective Action*, Olson argues that groups like the AMA approach the problem of member mobilization by offering benefits called "material incentives" over and above the collective goods attained through lobbying. These material incentives are defined as products or services that present some type of economic or monetary value for those who receive them, and unlike the collective goods, they can be selectively barred from non-members. The prospect of receiving these material incentives forces rational individuals to join the organization and contribute to the effort.

In organized medicine, examples of material incentives include the sale of special educational programs, peer-reviewed scientific journals, and annual conferences all of which non-members will not have access to. While some interest groups in other sectors may offer selective incentives free of charge once an individual becomes a member, physician associations

sell their most valuable material incentives to members, which is the basis for revenue generation (Olson 1965). Physicians who want access to these incentives and may need them for their practice are willing to pay for these program services in addition to member dues because the benefits are simply that valuable to them.

But where does lobbying come into this equation? According to Olson's "Byproduct Theory", the lobbying arm of an organization is merely a secondary function of the group and Olson follows a tight logic to reach this conclusion. First, he establishes that material incentives provide a more effective avenue for gaining formal members than lobbying alone, for the same reasons discussed above. Secondly, he argues that the primary goal of an organization must be recruitment and retention of members, because without members a group no longer exists[3]. Therefore, generating material incentives should necessarily take precedence over lobbying according to Olson, as these incentives are more effective in attaining a captive membership that will keep the organization alive. Thus in Olson's theory, lobbying is merely "a byproduct" contingent upon other activities or services which are the basis for membership.

Overall, Byproduct theory has its merits. First, it contrasts with a popular notion that organizations can be purely political and spend all of their capital on lobbying. Political scientists now know that this is unrealistic because it overstates the allure of policy objectives and assumes that every individual is purely politically-oriented. Byproduct theory, on the other hand, recognizes that otherwise-apolitical actors must be induced to join groups through such enticements as the material incentives Olson recognized. This explains why members who have no particular interest in politics may join an organization even if they are not motivated by the

[3] Of course, this does not explain those cases of new age interest groups which spend money on lobbying through a small staff but have no formal members who pay member dues. None of the organizations within organized medicine followed this particular strategy, but these types of organizations in other sectors might render this assumption incorrect.

policy goals of that group. This may explain why organized medicine still lobbies despite the fact that physician members may not necessarily be interested in politics.

Olson's byproduct theory has been celebrated by incentive scholars over the years[4], but it also has flaws. Operating within Olson's framework of purely self-interested actors, Hardin (1982) argues that if indeed the motivation for contributing to a group is purely driven by material incentives, Olson never explains why political entrepreneurs would form an interest group in the first place. Therefore, there must be some motivation apart from just material incentives, such benefits of organizing that Olson never adequately identifies. Frohlich and Oppenheimer (1970) similarly question Olson's framework by asking why leaders of interest groups who obtain a profit through membership dues would rationally—in accordance with their own self-interests—channel these resources towards collective goods. Paul Johnson (1998) adds a third shortfall as Olson fails to explain why parallel, competing organizations would not form to undercut the costs and membership dues of established organizations. Within organized medicine especially, we see that some organizations lay parallel claims to the same constituency of physicians at once. All of these arguments suggest that Mancur Olson's Byproduct theory is useful but perhaps incomplete in explaining interest group and member behavior.

Nonetheless, the Byproduct theory does provide one possible approach to collective action problem. If Olson's theory were correct, organizations should attain most of their revenue from not only membership dues but also from material incentives and services sold to individual members, as he predicted in 1965. Additionally, if the Byproduct Theory holds true within organized medicine, lobbying should only be a secondary activity as most resources are spent towards the creation of selective material incentives.

[4] See Michal T. Hayes (1986)

Clark and Wilson: "A Theory of Incentive Systems"

If Olson's theory proves incomplete in explaining how organizations approach and overcome collective action problem, Clark and Wilson (1961) go one step further by suggesting that organizations offer *three* specific categories of incentives, as opposed to Olson's one. First, organizations offer material incentives just as Olson devised. Second, groups also offer solidary incentives, wherein organizations confer the intangible benefits of fraternity, collegiality, and close interaction amongst members. Finally, groups offer a third category of purposive incentives in which members support supra-personal goals that never directly benefit them monetarily but from which they still derive utility by arguing for a cause.

The theory of incentive systems offered by Clark and Wilson provides a compelling explanation as to how organizations may overcome collective action problem, although there are questions as to the applicability of these incentive categories to all interest groups found today. For example, Clark and Wilson failed to envisage the rise of modern "check-writing organizations" that have offer very little infrastructure for member interaction (Hayes 1986). This would argue against the significance of solidary benefits as members are perhaps more motivated by other goals apart from interaction with others when they formally join an organization.

On the other hand, if the framework presented by Clark and Wilson is applicable to organized medicine, these three categories of incentives may have at least some role in the organizational approach to collective action problem. I also ask the additional question within this research: Does any one category of incentives seem to provide the most persuasive approach to overcome the difficulty in member mobilization as a result of collective action problem?

Walker: "Modern Interest Groups with Outside Funding"

While this chapter has focused heavily on incentive theory to explain organizational approaches to collective action problem, political scientist Jack Walker provides an entirely different perspective from scholars Olson, Clark, and Wilson.

Based on findings in his 1985 survey of interest groups across the country, Walker (1983) downplays the problem of collective action in lobbying and suggests that modern interests may be more concerned with the attainment of collective goods after all. In response to Olson's Byproduct theory in particular, Walker concludes that "collective benefits have a more potent attraction than Olson understood" (Johnson 1998, 40).

In contrast to the incentive theorists like Olson and Clark & Wilson, Walker writes that modern interest groups rely on outside sources of funding more than ever before. After employing this strategy, organizations are subsequently less concerned with the creation of selective incentives to mobilize members and generate revenue and instead more concerned with lobbying activities (King and Walker 1992). On interest groups in healthcare in specific, Walker highlights the impact of government funds, wealthy policy-motivated patrons, and foundation contributions among other sources of revenue, that have made membership dues and program services only one part of a group's funding strategy (Walker 1991, 9). In turn, this changes the dynamic of interest group politics such that while "the size of this constituency—the membership—waxes and wanes regularly", organizations still secure capital to meet their policy objectives through lobbying (Walker 1991, 84-85).

From his 1985 interest group survey, Jack Walker finds that organizations received on average 18.4% of their funding from sources outside the membership with some interest groups earning as much as 100% of their revenue from such sources (King and Walker 1992). If

Walker's theory on modern groups holds true within modern organized medicine, alternative funding strategies such as government grants, investments, royalties, and donor contributions should clearly give physicians' interest groups more capital to reach their policy objectives. I also tempt the question: Does increased outside funding lead to fewer incentives and more lobbying as Walker predicts?

Testing the Theories Presented

As clear from these three relevant theories on interest groups, there are multiple, alternative strategies for groups that encounter the collective action problem inherent in lobbying efforts. While none of these theories are entirely all-encompassing and none are entirely mutually exclusive, examining their applicability in organized medicine can give us a clue as to which strategies seem play the largest role for politically oriented physician associations.

Beginning in Chapter 5 of this work, I focus on incentive analysis to characterize the benefits given by these organizations. I specifically observe the extent to which material incentives, solidary incentives, and purposive incentives are each offered by these organizations within organized medicine. In chapter 6, I then examine the financial data of physician associations to examine how physician organizations create their revenue and generate expenses. Relying heavily on the Federal IRS Form 990 of each organization, I shed light on such variables as outside funding, member dues, program service revenues, and even lobbying in organizational budgets within organized medicine to see how they compare with Olson and Walker's predictions.

Chapter 3: An Overview of Politics for American Physicians

In this chapter, I begin by briefly reviewing physician political organization in the past as a comparison for organized medicine today. In subsequent sections of this chapter, I show how this traditional conception of organized medicine has changed over time.

As far back as the 1760s, American physicians began organizing in fledgling state and local medical societies (Stevens 1998, 18-20, 28-36). These societies were mostly a source of unity on scientific and economic grounds. Early societies published scientific journals for medical education and much like British guilds, they self-regulated the trade by determining patient fees. Doctors only gained a significant political presence at the national level after the American Medical Association reorganized in 1902 (Stevens 1998; Starr 1982).

Before the AMA reached preeminence in healthcare politics, the medical profession had notoriously abysmal standards for medical school training and was plagued with an overabundance of unqualified practitioners (Stevens 1998; Hiatt and Stockton 2003; Cox et al. 2006). After 1910, the AMA offered its knowledge of the industry to drive medical school reform across the country (Stevens 1998, 59-60). In the process, the Association killed two birds with one stone by both increasing the economic viability and the prestige of practice (Starr 1982). In just a few decades, physicians used the AMA to transform the profession entirely.

Physicians Led By the AMA

The history of physician political organization could consume volumes of work, but I emphasize the main point that the AMA was the premier medico-political organization of its

time. At the height of its power in the 1960s, it boasted a national membership rate of ninety percent of American physicians (Peterson 2001; Rayack 1967). And although specialization had begun as far back as the 1870s when Americans returned fresh from specialized German clinics, most specialty societies that had formed either deferred to the AMA on political matters or struggled with organizational problems that made it difficult to challenge the Association's representative role among doctors (Peterson 1993; Stevens 1998, 39-44).

Along the way to becoming a political powerhouse, the American Medical Association made some its most notable impacts on attempted healthcare reforms. Under both Presidents Franklin Delano Roosevelt and Harry Truman, it managed to strike at the heart of intense American fears of the Red Scare and fend off nationalized health insurance (NHI) as a form "socialized medicine" (Morone 1990, 253-284; Blumenthal and Marone 2008, 72-73). During the Truman Administration especially, the Association gained its reputation as having waged, at that time "the most expensive and sophisticated public campaign waged in American history" (Hacker and Skocpol 1997, 319). The AMA would later taste defeat when it failed to stop the passage of Medicare and Medicaid in 1965 but even then, doctors walked away with a significant victory in dictating physician reimbursement methods (Peterson 2001, 1156).

In retrospect, scholars such as UCLA's Mark Peterson (2001) are not alone in pinpointing the political successes of the AMA as the reason why physicians dominated medicine and healthcare politics for much of the century. Comparing it to other historically powerful organizations, Peterson suggests that only the AMA had all of the following assets simultaneously: information, regular connections with policy makers, formidable and dispersed membership, quasi-unanimity, organizational resources, electoral resources, coalition leadership,

and dominance of a policy niche (Peterson 2001, 1151-1152). Overall, the secret of physician power within medicine during this time seems hardly a mystery at all.

Incentive Theory in the Old Paradigm of Organized Medicine

In the absence of systematic incentive data or reliable financial data to analyze organized medicine in the past, it may still be helpful to build a profile for physician organization using the extensive literature on the AMA. I provide this analysis only insomuch that it characterizes organized medicine from a time period where the AMA represented as much as nine out of every ten American physicians in the 1960s (Rayack 1967). While this may slight other physician organizations that were also politically-oriented at the time, there simply exist fewer accounts of the activities of specialty societies during this time period when scholars were more inclined to write about organized medicine (Warner 1999).

Regarding the powerful AMA of the 1960s, economist Mancur Olson whose theories were mentioned in Chapters 1 and 2, provides one impression from this time period of physician political organization. Building on the works of Oliver Garceau, a noted AMA scholar, Olson (1965, 140) writes:

> In short, by providing a helpful defense against malpractice suits, by publishing medical journals needed by its membership, and by making its conventions educational as well as political, the American Medical Association has offered its members a number of selective or non-collective benefits. It has offered its members benefits which, in contract with the political achievements of the organization, can be withheld from nonmembers, and which accordingly provide an incentive for joining the organization.

To be sure, Olson put much stock into the idea that physicians organized around selective material incentives, and that these benefits attracted members based on their direct translation into some type of economic return.

In addition to the early use of selective material incentives, the AMA also employed a fair amount of coercion and intimidation. Strong arm coercive tactics included crippling professional sanctions levied against doctors who failed to conform to Association guidelines and others who violated so-called "ethical restrictions" set by the AMA (Thomson 1975, 1-18). As Olson recognized in *The Logic of Collective Action*, coercion has its role in organizations that seek a captive membership, and for the AMA these powers were largely unchecked before government anti-trust laws were applied to the profession in the late 1970s (Ameringer 2002).

Other important takeaways from the older organized medicine literature include mention of the AMA's organizational structure which, much like today, provided ample opportunity for physician interaction through state and local chapters (Rothman 1993). In fact, part of the AMA's political success was its far reach across the states. The AMA regularly enlisted physician members to lobby lawmakers in their home districts, while in the process "sympathetic neighbors" were also convinced of what was right and wrong in healthcare issues facing the country. Accounts of the AMA structure during this time suggest that solidary benefits did play at least some minimal role in the AMA membership incentive structure simply because the Association had an extensive network of state and local chapters for members to join[5].

---

[5] As noted earlier and mentioned again in data chapter 5, I have operationalized solidary benefits in a manner consistent with Hayes (1986) who counts state and local branches of an organization.

Important Developments Where Organized Medicine Literature Leaves Off

Since the late 1970s, comprehensive literature examining organized medicine begins to wane. Since then, a few important changes have taken place. In this section, I describe two particular developments and how they may affect the collective action problem faced by organized medicine over three decades later.

The first development was the application of stringent anti-trust laws on physician associations and societies by the Federal Trade Commission and the Supreme Court (Parks 1983; Light 1991; Ameringer 2002). First, the FTC targeted such organizational tactics as collective boycotts of non-conforming insurers and disciplinary actions against physicians who didn't follow organization guidelines[6] (Thomson 1975, 1-18; Laugeson and Rice 2003). Next, anti-trust laws prevented doctors from turning to their medical societies to pre-determine patient fees, an anti-competitive practice of price-fixing that was unregulated before[7] (Ameringer 2002). In 1978, the Supreme Court made the next move in *National Society of Professional Engineers v. US*[8], when it ruled that professional organizations—including but not limited to the AMA—could no longer force individuals to join a group in order to receive professional certification (Walker 1991, 77). The FTC then supplemented this decision years later by applying similar anti-trust logic to physician control over Blue Shield health plans, influence in accreditation and licensing, and power over independent practice associations (Ameringer 2002, 552).

If all of these changes were as impactful as some scholars suggest, American doctors today may no longer be as economically dependent on medical associations as before.

[6] The FTC actually sued the AMA in *Matter of the American Medical Association et al.*, 94 F.T.C. 701 (1979), where it specifically attacked the ethical restrictions on advertising that the organization placed on physicians within the practice. Without such advertising restrictions, doctors would otherwise be competing against each other to sell services for patients and healthcare consumers could therefore logically shop for medical services like other goods.
[7] First applied to medical associations as per the Supreme Court case *Goldfarb v. Virigina State Bar* , 421 U. S. 773 (1975)
[8] In *National Society of Professional Engineer v. US*, 435 U. S. 679 (1978)

Additionally, these organizations no longer wield the same coercive powers that helped them control the physician workforce in the past through the AMA. These consequences arguably make the incentives examined in Chapter 5 all the more important in member recruitment and retention today, in an age where these organizations have transitioned to more emphasis on the carrot of incentives after the losing the stick of coercion.

A second development that I emphasize within this thesis has also received little attention in the older literature. This has been the political impact of medical specialization. While few scholars wrote on physician organization during the 1980s, scholars writing in the 90s noticed a number of "special purpose medical associations" that lobbied independently of the AMA (Peterson 1995; Laugeson and Rice 2003). When the Clinton Administration proposed its Health Security Act, physicians were virtually hidden in the reform debates as these societies could not agree on whether to support or oppose healthcare reform (Quadagno 2004).

Somewhere between the late 1970s and early 1990s, scholars lost track of the specifics of organized medicine as American physicians began to derive their sense of professional identity primarily from membership in specialty societies and not from the American Medical Association (Stevens 2001; Lowery et al. 2005, 106). Over time, AMA membership has steadily dwindled from ninety percent of the physician workforce in the 1960s to fifty percent in the 1990s, to today as little as twenty percent of all doctors (Rayack 1967; Baumgartner and Talbert 1995; Peck 2007). With specialty groups better able to meet the professional and educational needs of practitioners, specialty-driven divisions have officially ended the AMA's quasi-unanimity for all physicians (Peterson 2001). This development even led to a perspective piece within the Journal of the American Medical Association posing the question: "Is it time for the end of organized medicine as we know it?" (Booth 2000)

While the AMA has experienced a notable decline from an organizational perspective, it still remains a formidable political group with its spending on healthcare lobbying. However, in the new paradigm of healthcare politics for doctors, organized medicine is now comprised of more national medical societies than ever before. In this thesis, I consider this crowded policy field of interest groups representing physicians and how this seems to affect the approach by these organizations towards collective action problem today.

Moving On: Modern Healthcare Politics for Doctors

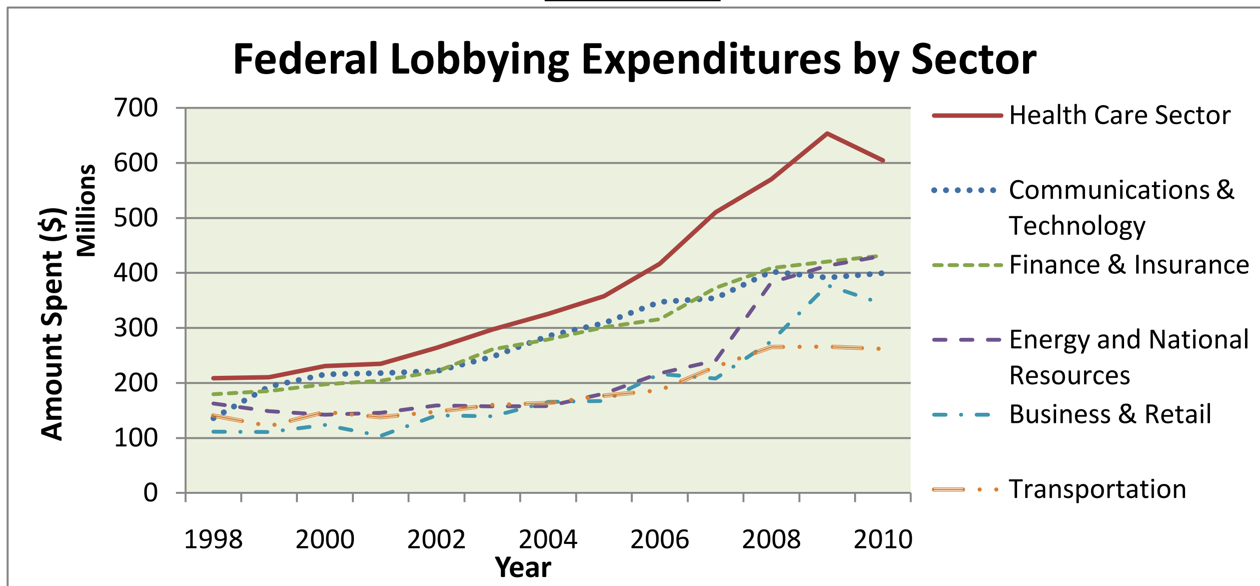
In the years 2009 and 2010, the fervor for reform brought healthcare issues to the national spotlight. The topics of healthcare access and reform of the system certainly deserve much attention, yet these are not the only issues that bear relevance to the delivery of health services. Healthcare politics for doctors and for other parties interested in health policy boils down to many other complex issues over and above healthcare reform. But the arguable flaw with contemporary writing on modern organized medicine is that it highlights physician organization and schisms that arise within the context of healthcare reforms. While better than no scholarly work at all, this does not provide the full perspective of physician organization.

Examining physician associations in the context of healthcare reforms oversimplifies the complexity of political issues that arise for doctors. A few examples here may be illustrative. For instance in the late 1990s, the AMA began to push for a piece of legislation referred to as the Campbell Bill, so called after its sponsor Tom Campbell (R-CA), which would allow doctors to collectively bargain against managed care organizations (Baumgartner et al. 2009). In 2003, when Medicare part D coverage was expanding to include prescription drug coverage, doctors were right alongside pharmaceuticals and businesses that lobbied over its provisions (Hall and

Van Houweling 2003). Other healthcare issues can recur year to year. Take for example how doctors lobby Congress annually to delay scheduled Medicare reimbursement rate cuts (Laugeson 2009). And whenever lawmakers consider medical malpractice reform, doctors tend to lead the discussion (Morone, Litman, and Robins 2008). Even today, physicians can be found in Washington discussing entirely new issues from the ones mentioned above. In 2010 and early 2011, for example, there has been debate on a new payment model incorporating Accountable Care Organizations (ACOs) that would incentivize quality of care by instituting pay for performance in physician reimbursements (Gold 2011).

From the complexity of issues for American doctors alone, one can understand how lobbying expenditures throughout the healthcare sector have trumped those of *every other sector* in the United States for the last 12 consecutive years (See ***Figure 3-1***[9]). This surprising fact is observed even at times when high-profile healthcare reform legislation is not being considered in Capitol Hill (Marone, Litman, and Robins 2008). Just as healthcare has expended to unprecedented costs, so too have the political stakes.

Figure 3-1



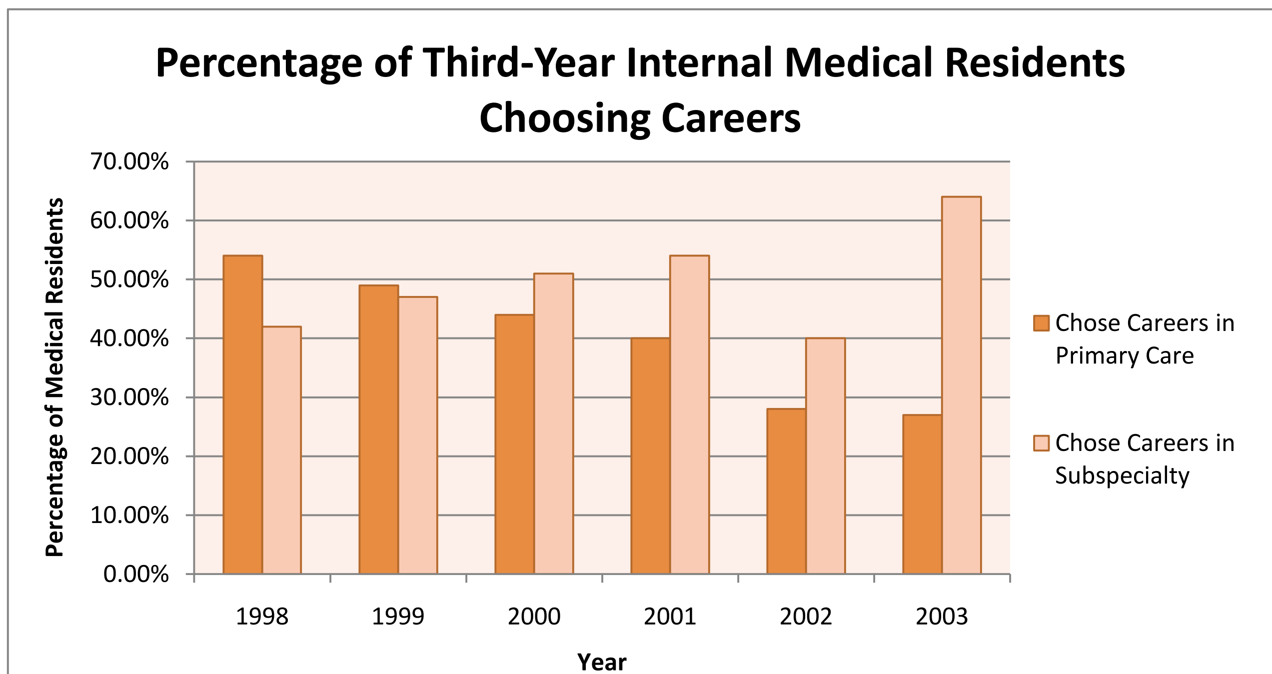
[9] Data from CQ Money Line. Mentioned in Marone, Litman, and Robins (2008)

Specialist Dominated Medicine

As mentioned earlier, organized medicine has undergone internal, structural change in response to specialization. The AMA remains formidable as the heaviest lobbyer within organized medicine, but it has now abandoned its national constituency of all physicians in favor of primary care doctors[10] (Dorin 2010).

These political trends may be even more relevant as we look towards the future. American medicine is becoming only *increasingly* specialist-dominated with time, which may not bode well for the AMA. ***Figure 3-2*** below is adapted from Bodenheimer (2006) and highlights some of the latest data showing how fewer medical students enter careers in primary care. Garibaldi et al. (2005) suggests that over 80% of residents in Internal Medicine may now choose to be specialists.

Figure 3-2



[10] For those who may be unfamiliar with the term, "primary care physicians" are doctors who serve as the first point of contact for a patient with the healthcare system. These doctors deliver continuing preventive care and ongoing curative care as appropriate. If necessary, primary care physicians refer patients to specialists to seek further medical treatment. Examples of primary care physicians include family doctors and most pediatricians.

While not true in every case, the general advantages can be skewed towards specialization instead of primary care. Some specialties feature more predictable work hours, more competitive compensation, and a limited range of conditions treated (Bodenheimer et al. 2007; Stevens 1998). In return for extra training, students can choose to be specialists in a particular area of practice.

To show the reader how complex medicine has become, there are 26 specialties officially recognized in American medicine, and many more perhaps yet to be recognized. A few examples include otolaryngologists known as Ear, Nose, Throat (ENT) doctors, dermatologists who focus on conditions of the skin, and neurologists who deal with disorders of the nervous system. In addition to the 26 main specialties recognized for physicians in the United States, there are also "subspecialties" within these specialties. I encourage the reader to observe the Appendix under Section A-1 for a more thorough list. A cursory glance is enough to demonstrate the dramatic degree of specialization and sub-specialization within American medicine.

Over the years, many have argued that the trend of increased specialization impacts both the cost and substance of American healthcare (Politzer 1991; Parchman and Culler 1999; Grumbach 2002). Specialists may be vital to focused aspects of medicine however primary care serves as the first point of contact for patients and the drop in primary physician workforce may be impactful for health outcomes. Studies such as Shi et al. (1999) and Shi and Starfield (2001) find that greater access to primary care has been associated with lower patient mortality rates and lower incidence of disease.

While such research places specialization into perspective with regards to health outcomes, this thesis shifts the focus and considers the possible *political* implications of this same specialist-driven fragmentation. This nascent field of research merits more attention and I

begin by asking how groups within modern organized medicine approach collective action problem today, especially given the rise of specialty-dominance.

Chapter Recap

Though the AMA once served as the most significant organization representing doctors, over time it has lost its representative role among all physicians in the country. The organization may still be the leading figure in healthcare politics for doctors but other organizations have arisen with a narrower focus on particular medical specialties and now lobby on their own in Washington, DC. One major blow to the powerful AMA was the application of anti-trust restrictions in the 1970s and 1980s. Yet, even more impactful has been the increasing trend of specialization and sub-specialization that has created diverging interests among doctors and a new paradigm for organized medicine altogether.

Chapter 4: Inclusion Criteria and a Profile of Organized Medicine

> Before data chapters 5 and 6, this chapter focuses on the inclusion criteria for groups studied. It then provides a brief examination of the lobbying in organized medicine.

Truth be told, most Americans would find it surprising to see their family physicians lobbying in Washington, DC. While most doctors may not take such direct measures to influence policy, the scenario is illustrative. Healthcare settings seem detached from the world of politics, and few draw connections between government decisions and the delivery of health services apart from such well-known programs as Medicare and Medicaid. But whether most American recognize it or not, millions of dollars are spent each year by organizations that represent physicians on policy matters. While no research characterizes these organizations comprehensively, I offer this chapter as an updated profile of organized medicine and a precursor to subsequent data chapters to follow.

Methods: Inclusion Criteria for Organizations in This Thesis

Though it may be difficult to find a reliable and extensive list of all national medical associations in the country, in this thesis I focus on organizations within organized medicine which spent money on lobbying. I found my organizations by searching industry profiles given by the Center of Responsive Politics (CRP) from 2006 through the year 2010, giving this study a full five year span. The CRP, a well-reputed independent organization, publishes records of lobbying expenditures and campaign contributions reported at the federal level on its website, OpenSecrets.org.

Intuitively, using the Center for Responsive Politics to find my organizations in this way creates the limitation of excluding physician organizations that chose not to report policy activity during this particular time frame. However, as the data represents the latest lobbying information available at the time of this writing, this limitation is relatively minor from a policy impact perspective. Organizations which neither spent on lobbying nor campaigns at a national level in the last five years were not listed in the CRP industry profiles and most likely have a minimal role in influencing national health policy.

To my surprise, I found that physicians' professional organizations on the CRP website were listed not only within the Health Sector but were also classified in the Human Rights Sector. To cast a wider net and include other physician professional organizations I additionally searched the Education Sector as many of these organizations claim to engage in issue advocacy and education of the public. Another potential limitation in this search method is that organizations that were further misclassified by the CRP and listed in other industries may not have been included in this list, but after my own quality control check of other sector profiles, I believe this had negligible effect.

As part of the inclusion criteria, I sought any organization which represents physicians as a whole or which represents a specific subsection of doctors in the form of a medical specialty organization. Specifically excluded were organizations not considered part of organized medicine, including those associated with: health enterprises, medical care systems, pharmaceutical companies, medical schools, hospitals, insurance companies, or non-profit research foundations. I also excluded a gray area of nonprofit organizations such as: the American Diabetes Association, the Leukemia & Lymphoma Society, the American Cancer Society, the American Public Health Association, and the American Heart Association. While

these organizations fit many characteristics of physician professional associations, these non-profit, charitable disease societies are considered a class of their own and have hindered the growth of physician professional organizations by offering selective incentives to compete for members (Galvin 2002).

The final list features 81 organizations which resulted from this search strategy. I encourage the reader to observe Section A-2 of the Appendix to briefly examine the number of organizations, the years of incorporation, the general membership size, and a sense of the primary constituency of physicians to which these organizations cater.

A Brief Profile of Organized Medicine: 2006 Through 2010

Before delving into the incentive systems and the financial aspects of organizations within organized medicine, an important contribution of this paper is to update the profile of organized medicine. This section features a short description on a few characteristics of these organizations, creating a context for Data Chapters 5 and 6.

When These Organizations Formed

Table 4-1 breaks down years of formation for these eighty-one organizations by decade. As this table shows, all but six were founded after the 1900s when the physician political movement gained momentum through the AMA.

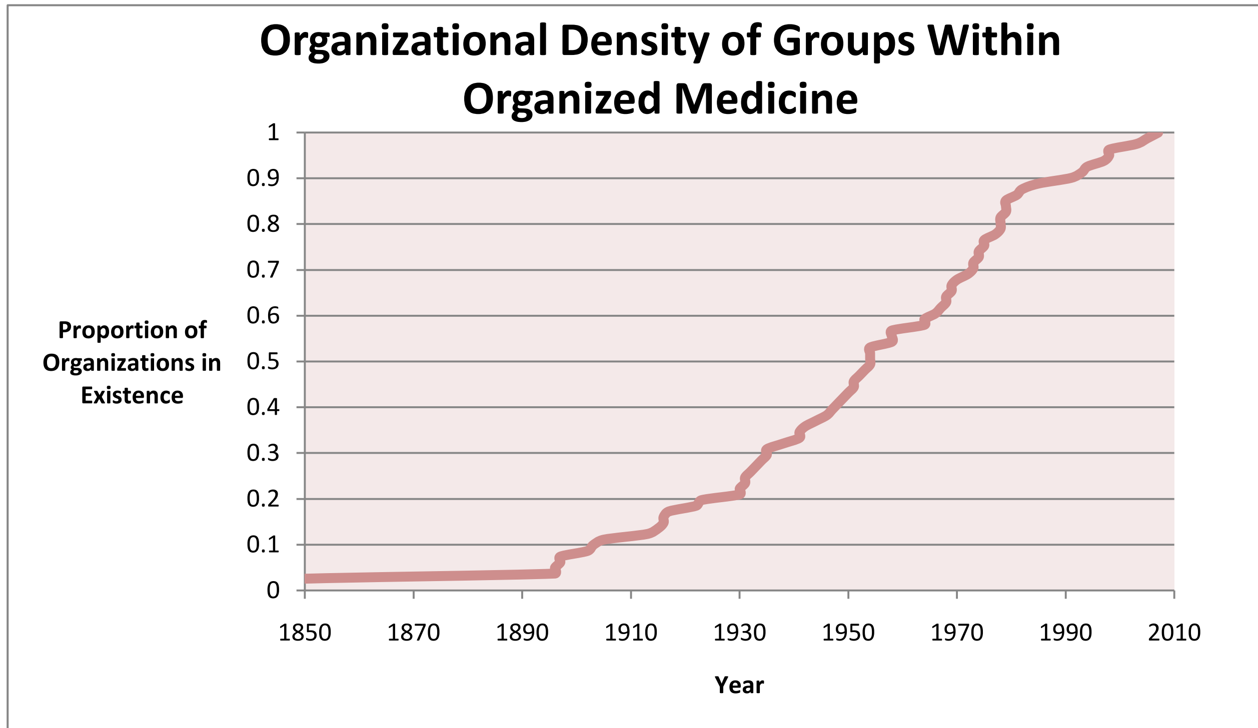
Table 4-1

Organized Medicine by Age	
Year of Formation	Number of Organizations
Post-2000	3
1990-2000	6
1980-1990	3
1970-1980	15
1960-1970	8
1950-1960	12
1940-1950	8
1930-1940	10
1920-1930	2
1910-1920	5
1900-1910	3
pre-1900	6

An additionally helpful graphic is ***Figure 4-1***, showing organizational density by decade. This type of density graph,

employed by Walker (1991), can be particularly useful to show sectors that experience sudden spurts of organizational growth. As ***Figure 4-1*** shows, two fertile growth periods for organized medicine existed in the 1940s to the 1960s and after briefly tapering off, again in the 1960s to 1980s.

Figure 4-1



The most surprising finding is that most organizations were formed prior to the 1980s. Paul Starr, who won the Pulitzer Prize for *The Social Transformation of American Medicine,* was one of the last to comprehensively study organized medicine from a historical standpoint and he writes that in 1982 the AMA was most concerned with the rise in the physician workforce outpacing membership (Starr 1982, 427). Starr makes no reference to the political impacts of specialty societies and specialist associations of the time. ***Figure 4-1*** nonetheless shows that at the time of his writing, a full 87.6% of these organizations were already incorporated. This may

suggest that the political involvement of these organizations was a more recent phenomenon than what the comprehensive organized medicine literature could describe.

Organized Medicine in the Larger Health Policy Domain

After finding the years of formation for these organizations, where do these groups fit in the larger context of healthcare sector lobbying today? The year by year breakdown of lobbying expenditures is provided in ***Table 4-2*** while ***Figure 4-2*** graphically represents the spending that comes from these groups. For the five year period of 2006 through 2010, these 81 organizations spent an average of $44.6 million in lobbying per year.

Figure 4-2

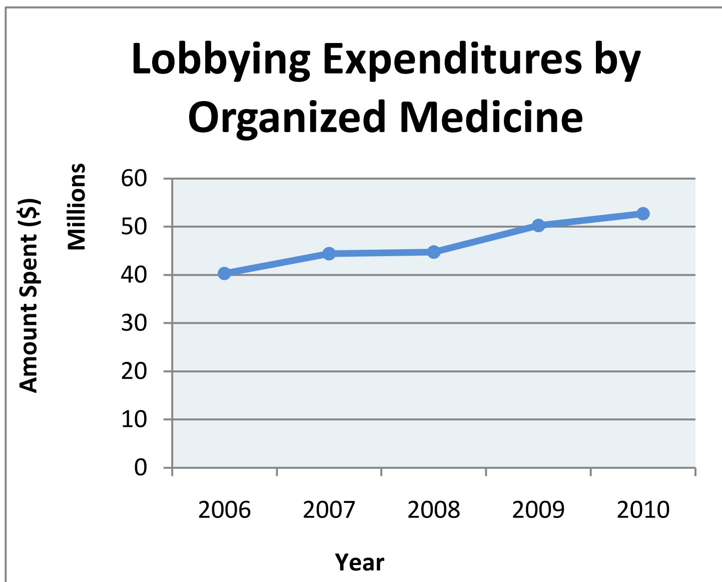


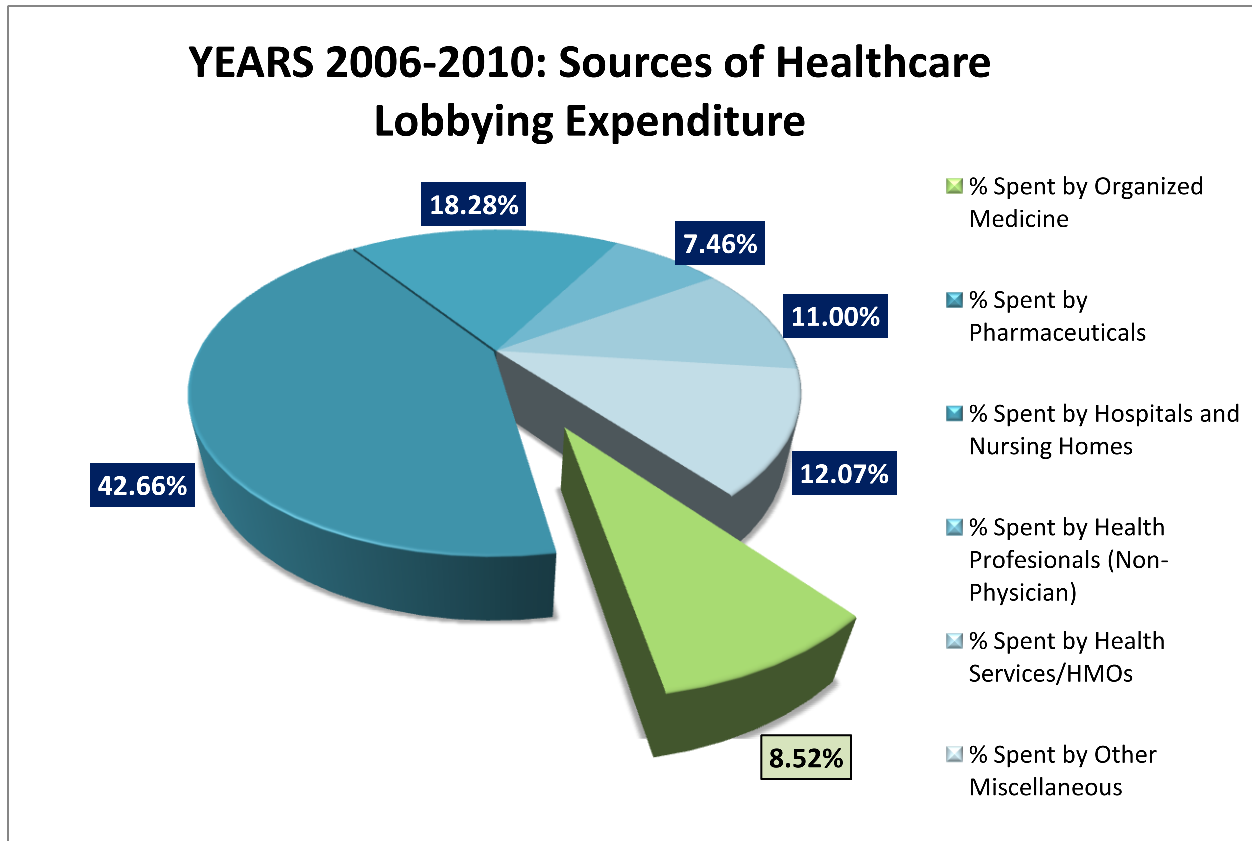
Table 4-2

Lobbying Expenditures by Organized Medicine		
Year	Amount Spent ($)	As a Percentage of Total Healthcare Sector Lobbying
2006	40.3 Million	9.66%
2007	44.3 Million	8.69%
2008	44.7 Million	7.84%
2009	50.2 Million	7.68%
2010	52.7 Million	8.72%

During the earliest year I study within this thesis, the year 2006, physicians accounted for as much as 9.66% of total sector lobbying. During later years, this figure waned to slightly below 8%, but this was more indicative of a rise in spending by other organizations lobbying in the healthcare sector, not of any decrease in lobbying by organized medicine. Overall, during this

five year period physicians accounted for approximately 8.52% of lobbying expenditures in the sector, shown by the pie chart in ***Figure 4-3***.

Figure 4-3



Chapter Recap

Generally speaking, almost nine in ten of the organizations studied within this thesis were already formed by the early 1980s, with the implication that many specialty societies and associations may not have begun lobbying until after this time period. This explains why older literature on organized medicine fails to described their policy activity.

All told with specialty societies included, organized medicine accounted for on average, 8.52% of spending in the sector each year between 2006 through 2010.

Chapter 5: Incentive Systems in Organized Medicine

The following chapter borrows elements from Olson (1965) as well as Clark and Wilson (1961) to describe the incentives given by physician professional associations in order to overcome the collective action problem. The chapter begins with a description of methods then analyzes each of the three categories of incentives between material, solidary, and purposive benefits.

As 1972 approached, Congress had a problem on its hands with Medicare. After the program had been introduced seven years earlier, healthcare costs had risen at an alarming rate of thirteen percent per year (Holtz-Eakin 2004, 13). These costs stemmed from local claims processors who served as arbiters of physician reimbursement rates. These claims processors had no reason to curtail the compensation of local doctors with whom they had built close relationships over time. In response to this flaw in the reimbursement system, lawmakers created the Medicare Economic Index to hold fees down to a new national cost estimate (Laugeson 2009). But physicians were simply seeing a higher volume of patients and healthcare costs between 1970 and 1988 increased at a pace of sixteen percent per year (Helbing, Latta, and Keene 1991).

Seventeen years later, in 1989, Congress believed it finally had the solution. Lawmakers would make use of national medical societies which they believed were similar to the German regional, corporatist-style medical societies that held down costs within the German healthcare system (Mayes and Berenson 2006; Laugeson 2009, 167-168). Given a new national expenditure formula, American medical societies would in theory focus on cost containment to assure reaching the national target set by the Medicare Economic Index. They would also coordinate

across different regions in the country to make sure that physicians were receiving equitable pay and practicing by comparable standards (Ginsburg, LeRoy, and Hammons 1990, 182).

Unfortunately for Congress, this view of the professional societies was sadly mistaken. American professional societies were fundamentally different from the German societies to which they were frequently compared. Contrary to the belief of lawmakers, these groups were *not* formed for the sake of regulating costs and practice. So while Congress thought these groups would be the answer to rising healthcare outlays, there was neither the carrot nor the stick to provide incentives for this (Laugeson 2009, 167-168).

But if the physician associations do not prioritize cost containment goals, then what are they offering? This chapter develops a clearer answer.

Theories Reexamined

As mentioned in Chapter 2, incentive theorists within political science argue that organizations that lobby, such as those we see in organized medicine, approach collective action problem by incentivizing membership for individuals. These created incentives can be selectively given to members and withheld from non-members so as to provide a benefit that can only be gained if an individual formally joins the organization. Olson (1965) places particular emphasis on material incentives, those tangible rewards to membership which translate to some economic or monetary return for members. Clark and Wilson (1961) similarly recognize these material incentives but add two other categories of intangible benefits which organizations can offer. These include solidary benefits, defined as the return of social interaction with other members, and purposive incentives, defined as the intangible benefits of arguing for greater

supra-personal goals or causes which give no direct benefit for members (Clark and Wilson 1961, 135).

In the 1980s, Congress not only misunderstood the organizational basis of specialty societies, but overestimated the importance of purposive benefits in curtailing costs and improving healthcare quality by standardizing care. What are the incentives behind these same organizations nearly two decades later? In this chapter, I examine incentive systems which galvanize members to join an organization.

Chapter Methods

To analyze material incentives, I mined extensively through organizational websites and IRS Form 990s to find the incentives offered by these organizations. After examining all 81 organizations with great care, I noted 62 distinct material incentives offered and noted which organizations offered each and which did not. I substantively recoded the data by collapsing these 62 incentives into 25 final categories of material incentives which can be seen in Appendix A-3. Following a procedure similar to the creation of simple dummy variables in regression, I coded organizations as "1" for a category if the organization offered that incentive and "0" for the category if not. Of course, one limitation of using 0-1 variables is that this weights all material incentives equally in terms of their value, but I argue that it is difficult regardless of method to justify which incentives are more valuable than others and by exactly how much. For the rest of the chapter, I refer to an "incentive score", meaning the number of categories out of the total of 25 categories of material incentives that were offered.

Regarding solidary benefits, I operationalize them using the method from Hayes (1986) to count state and local branches of each organization. Organizations with more infrastructure for

member interaction formalized into organizational hierarchy would be expected to provide more solidary incentives than organizations that merely collect checks or otherwise rely on members' initiative to attend annual national conferences. To determine the number of state and local branches of each organization, I referenced each organization's latest available IRS Form 990, which in most cases was for the year 2009. I then cross-checked these IRS filings with the data on each organization's website to confirm the number of state and local chapters across the fifty states.

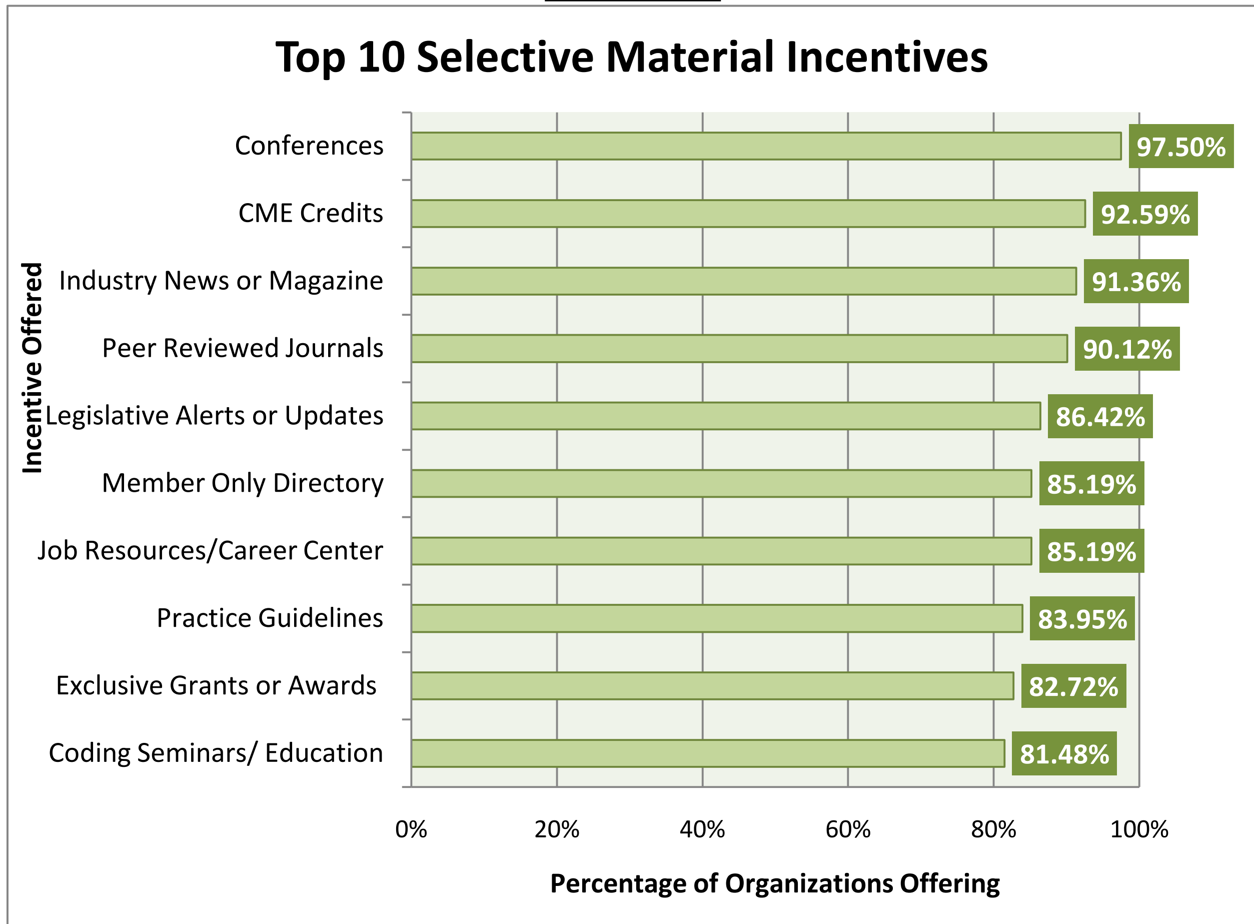
Finally, for purposive incentives, I operationalize them by finding the number of overall purposive issues that each organization lobbies for. To do this, I searched lobbying profiles of each organization from the years 2006 through 2010 and classified all issues which they reported lobbying on. While some organizations may be more specific as to their lobbying activities, I provide my best effort to provide some precision in a generally imprecise dimension. If lobbying issues were truly altruistic as Clark and Wilson (1961) frame purposive incentives to be, these issues were considered "purposive". Therefore, if organizations reported lobbying activities for any legislation wherein members or the group itself would not receive any type of grant, research funding, additional federal reimbursement, or any other economic return for any service, this was counted as a purposive issue.

Material Incentives in Organized Medicine

Incentive theorists give material incentives the most attention of the three categories. Of the three categories discussed in this chapter, material incentives are the only tangible of the benefits available. In ***Figure 5-1***, I present a list of top 10 selective material incentives given by

these professional associations as an example of how physician societies and organizations induce membership materially:

Figure 5-1



As the figure shows, the number one material incentive within organized medicine is the offer of annual meetings by organizations. Seventy-eight of the organizations provided conferences for primarily scientific purposes but an additional finding was that forty-three of the organizations (fifty-three percent) offered special, separate meetings for political involvement.

Other incentives listed give members the invaluable benefit of information. One example from the top ten list from ***Figure 5-1*** includes industry news publications to keep members up to date on the happenings of the sector and the health market. Many organizations also offer

legislative updates to keep members informed of developments in regulations and physician reimbursement issues. I note that while not all members may be politically-inclined, changes in federal and state guidelines impact all practitioners, making this resource invaluable. Finally in addition to legislative updates, one cannot discount the value of peer-reviewed journals which offer both the latest research and provide opportunities for publication. This proves particularly important as many modern specialties fight for recognition through increased research that substantiates the importance of their work.

Groups within organized medicine also offer many important career tools to members. Continuing Medical Education (CME) Credits, the number two material incentive on the list, are essential credits earned towards maintenance of licensure. Only organizations with accredited courses can offer these credits and each state may have different CME requirements. Apart from CME credits, physicians looking for jobs can also find Career Centers in eighty-five percent of these organizations, providing access to employers directly through an association.

The remaining incentives in the top ten include clinical practice guidelines, grants and awards, and member-only directories. First, clinical practice guidelines can be helpful to follow industry standards on procedures, particularly useful for physicians operating in litigious environments. Awards and grants, offered by nearly eighty-three percent of organizations, recognize physicians for advancements within practice and fund scientific research. Finally, member-only directories give physicians access to mailing lists and contact information of other members. While these directories may be sold for commercial purposes to non-members for up to five hundred dollars, members get immediate access upon joining.

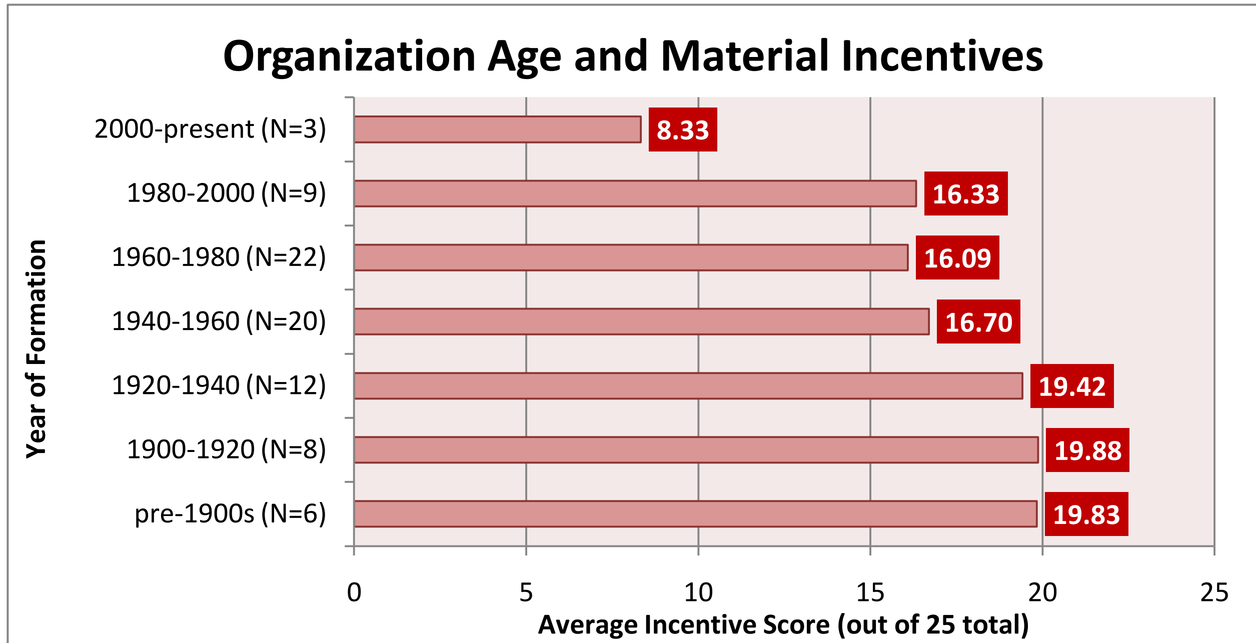
Once these specific material incentives were categorized into the twenty-five variables described in the Methods section above and seen in Appendix A-3, I find that the average incentive score for organizations across organized medicine is 17.1 out of a total 25 possible.

Organization Age and Variation in Material Benefits

While an average organizational incentive score of 17.1 describes the breadth of material incentives offered in general, I also consider how groups may vary in their reliance on selective material incentives based on organization age. This may clarify how the comparatively newer age organizations may have differing emphases on material incentives than older organizations.

One reasonable hypothesis is that older, more established organizations with a footing in the industry offer fewer incentives. This idea accords with the works of incentive theorists such as Salisbury (1969) who argue that new organizations that form face a heightened collective action problem. Not only do these organizations need to provide incentives to offset costs of membership, but also these organizations would need to provide a greater incentive than existing organizations. In a crowded field of groups often laying parallel claims to the same constituency of physicians, one would expect this to be the case. Separating organizations into distinct eras by year of formation, I compare how member incentives vary with age of the organization. ***Figure 5-2*** shows the result. As this figure suggests, older organization tend to give *more* material incentives on average than newer organizations. While the figure shows organizations and dates of formation with twenty year intervals, the identical relationship was evident when categorizing organizations by each decade. This provides evidence against the hypothesis that newer organizations would give more incentives as a way to lure members from much more established groups like the AMA. med in the Post-2000 era where the SD for incentive score was 7.

Figure 5-2



Why might older organizations be offering more material incentives? The answer is not necessarily size of organization alone, a variable which will be considered next[11]. But one can consider many other possibilities. While shying away from causality, a relationship which is difficult to establish through descriptive analysis, I do offer possibilities. Older organizations have simply had a longer period of time to revise their membership strategies and may have, over decades, added more material benefits as they've lost their coercive controls with anti-trust regulations. Alternatively, older organizations may rely more upon traditional material incentives where new organizations may offer more inducements of the solidary and purposive variety. More on this possibility comes later in this chapter.

---

[11] When finding the correlation between organization size (by members) versus age of organizations (in years), the result is r=0.35. some of the oldest organizations such as the American Academy of Ophthalmology only cater to a specific subset of physicians and therefore only have around 7,000 members despite being founded in 1896. In contrast, organizations such as the Alliance for Specialty Medicine were incorporated in 2003 but this particular organization has over 200,000 members.

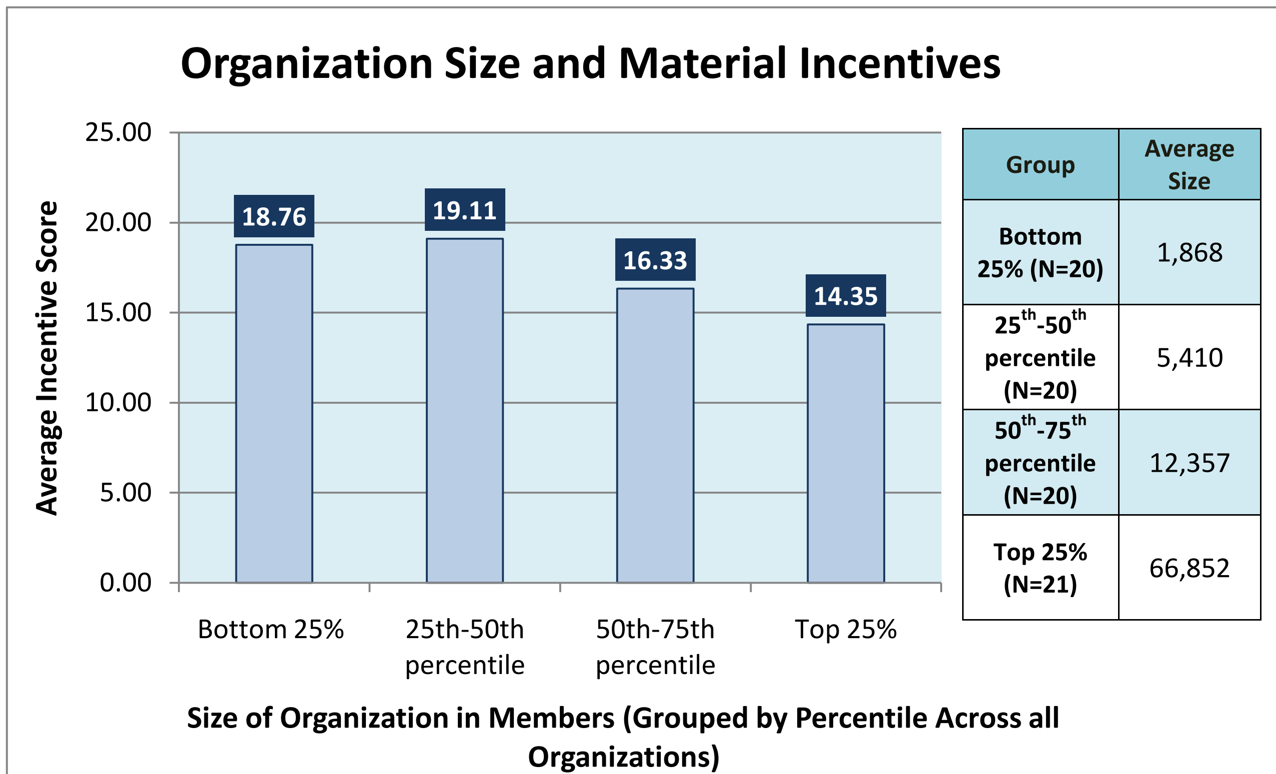
Organization Size and Variation in Material Benefits

To further analyze material incentives, I also consider how the number of members in an organization affects the breadth of material incentives given. Incentive theorists such as Olson (1965) argue that larger organizations generally face a heightened collective action problem as compared to small groups. He argues this because individual-level behavior is more difficult to monitor when organizations have more mass appeal, but small organizations run high on member accountability which usually relies recruitment and retention on a more personal level. While there are many potential exceptions to this theory, I nevertheless consider how well incentive theorists predict the behavior of organizations based on size.

In ***Figure 5-3***, shown on the next page, I separate organizations into four distinct groups by quartiles based on member size. Next to the chart, I offer a table describing the average number of members for organizations within each of the four groupings.

As the figure shows, larger organizations instead provide *fewer* incentives than small organizations on average. Comparing the top twenty-five percent and the bottom twenty-five percent of organizations based on size paints a particularly vivid picture, for although the latter category was on average thirty times larger, this grouping generated an average incentive score that was lower by four points on average. Incentive theory within collective action problem fails to predict how these organizations handle the collective action problem based on organizational size alone. If larger organizations do indeed face a heightened collective action problem, this is not reflective in the number of material incentives they offer to members.

Figure 5-3



Group	Average Size
Bottom 25% (N=20)	1,868
25th-50th percentile (N=20)	5,410
50th-75th percentile (N=20)	12,357
Top 25% (N=21)	66,852

Does Intra-specialty Competition Spur More Incentives?

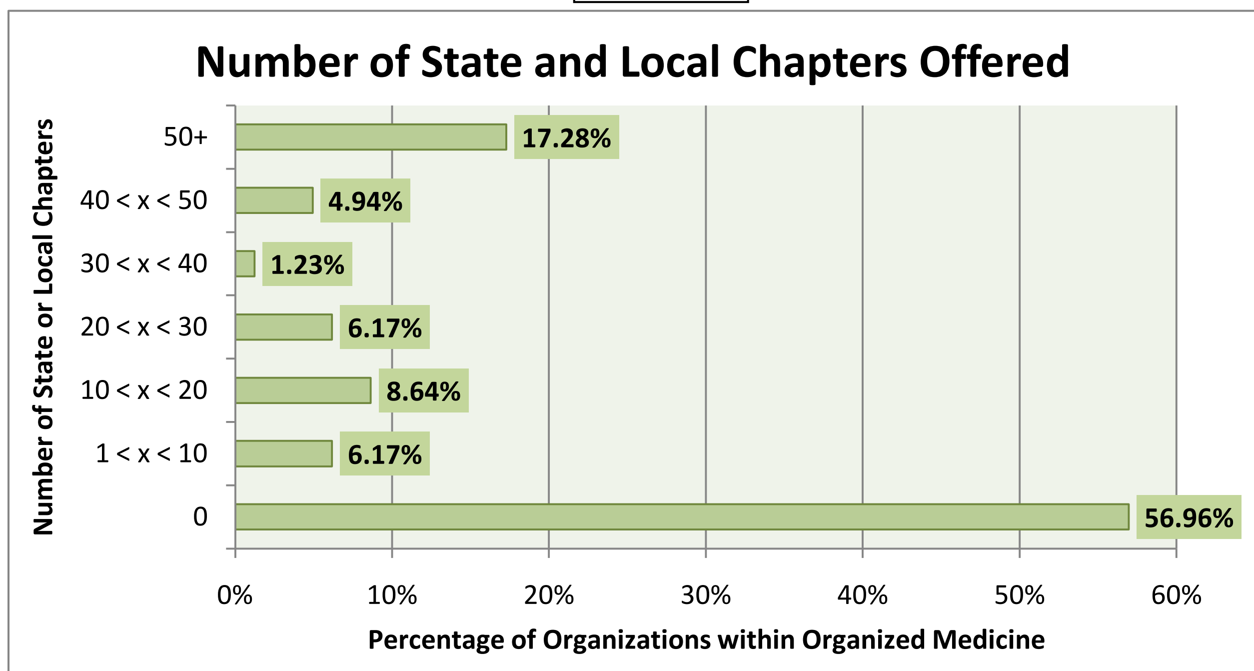
Finally, one can consider how intra-specialty competition should affect the number of incentives given. One intuitive guess would be that multiple organizations laying parallel claims to members results in a greater challenge in luring and attaining members. The standard to overcome collective action problem should be raised when potential members have much choice in where they can join an organization. Groups would be expected to offer more incentives in direct competition with each other.

But while the analysis was made with regards to the data, I find that the results are mostly inconclusive and that organizations may not necessarily offer more selective material incentives to members in response to more competition. While I spend no more time examining this analysis, I provide a figure within Appendix A-4 for the reader more inclined to see this.

Solidary Incentives in Organized Medicine

After considering material incentives which provide economic or monetary return, the next category according to Clark and Wilson are solidary benefits. These include benefits such as a sense of community, fraternity, and networking that comes from close interaction of members. As mentioned earlier, I borrow from the work of Hayes (1986) who measures solidary benefits by finding the number of state and local chapters provided by organizations. Hayes suggests that associations with more state and local chapters provide greater infrastructure for solidary benefits such as close interaction and collegiality. In ***Figure 5-4,*** I present an overall perspective of state and local affiliates offered by organized medicine:

Figure 5-4



Surprisingly, over 56% of organizations report in their IRS Form 990s that they have no state or local chapters, and meanwhile make no mention of having such affiliates on their websites. Some organizations offer recognition of "regions" where member practice, but again

have no formalized structure in these regions. Other organizations offer advice, assistance, and funding for state and local medical societies that apply to the organization, but once more have no formal branches in any states. For those who have yet to form any localized affiliates in the states, some show interest in forming chapters but have yet to mobilize them.

In organizations with no state or local affiliates apart from national headquarters, solidary benefits are largely contingent on members' motivation to attend national events. Instead of having formalized state structures, many groups offer educational courses, annual scientific conferences, or other such national meetings where solidary incentives are simply a welcome byproduct of other incentives that are more material in nature. This suggests that while almost all physician organizations may have a significant allure through material incentives, solidary benefits may play a smaller role in keeping old members and attracting new ones.

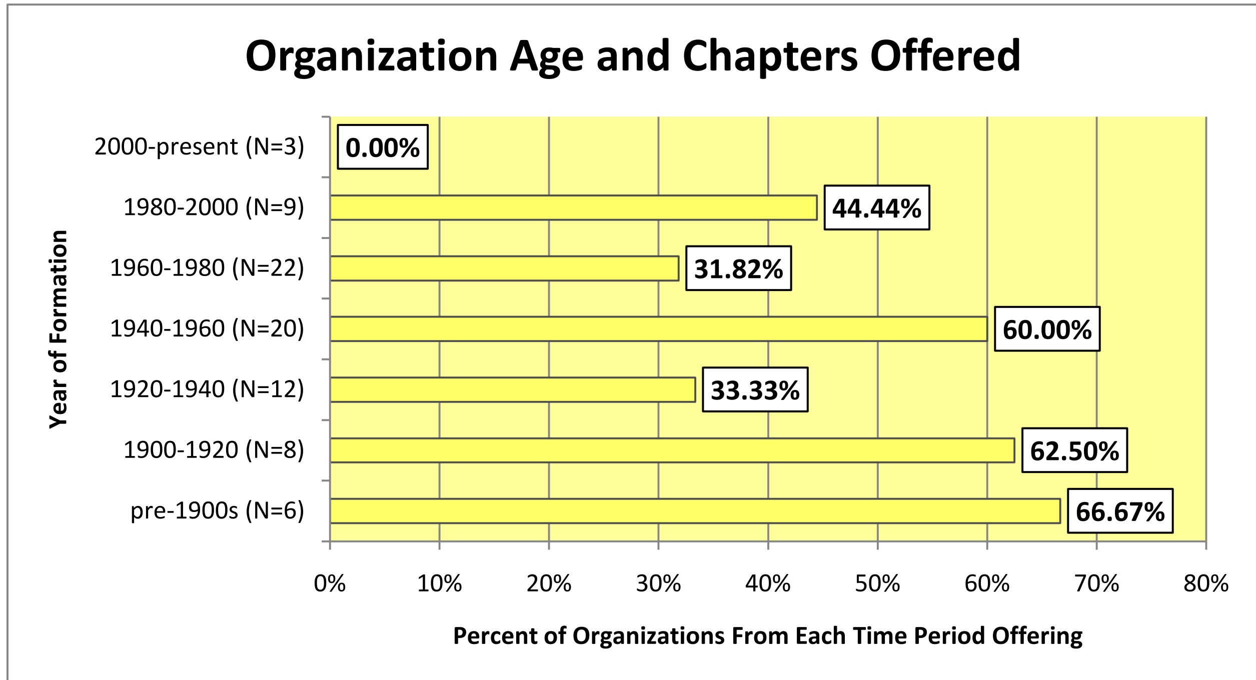
As these findings shift the conception of how these groups operate, I focus on the broader question of which of these organizations offer such localized affiliates at all.

Organization Age and Variation in Solidary Benefits

To examine the variation in localized affiliates offered, I eschew the use of an average of state and local branches in this section. While one limitation is that this weights organizations equally on the score of solidary benefits whether offering ten chapters or one hundred, I suggest that this is a preferable limitation to offering an average and having numbers skewed by large outliers like the American College of Surgeons which offers an unparalleled one hundred formal affiliates. If organizations have made any effort to build regional or localized affiliates within their hierarchy, I consider this to provide more infrastructure for solidary benefit than any organizations that otherwise have no affiliates.

Given this reliance on percentages, ***Figure 5-5*** breaks down organized medicine by the same distinct eras of formation as earlier in the chapter:

Figure 5-5



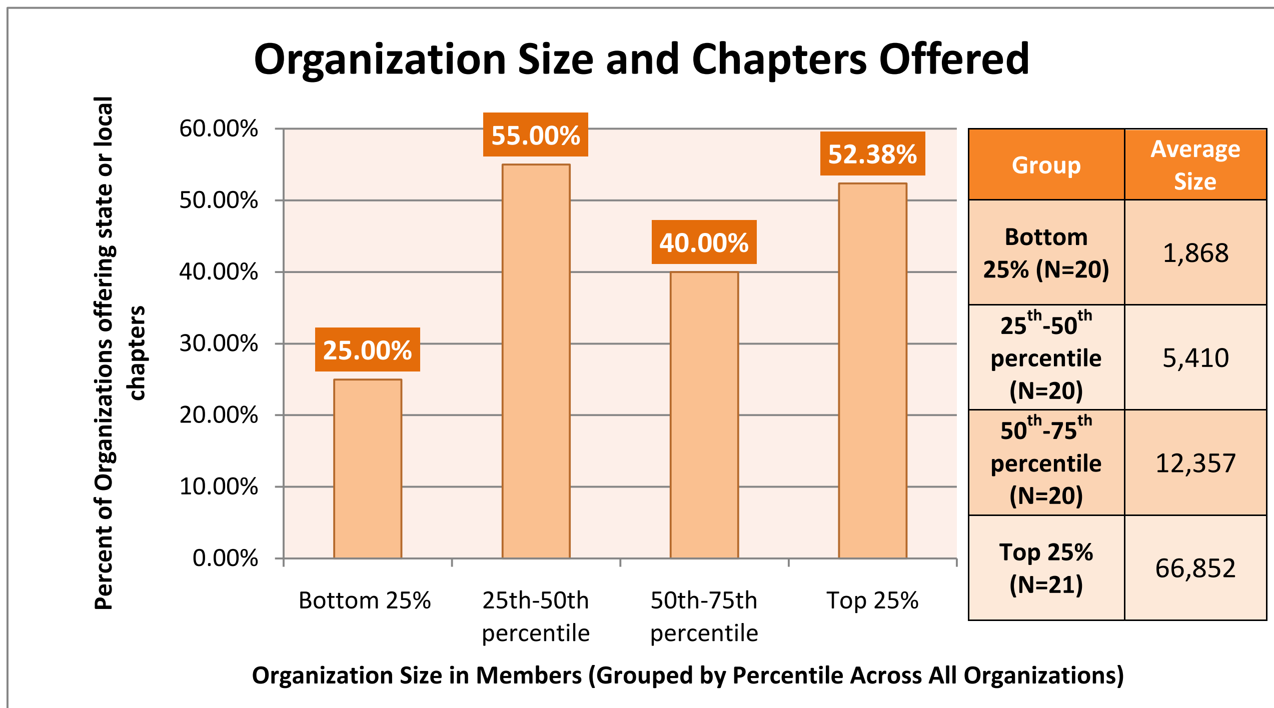
Overall, the numbers do not show any strictly linear relationship between the year of formation and the percentage of organizations providing state or local chapters, but ***Figure 5-5*** illustrates how the oldest organizations generally offer formalized local and state chapters more than the newer organizations do. Of course, the definition of new and old is once again relative.

Seen here, a majority of groups formed before the 1960s have some formal state or local chapters within their hierarchy while in contrast, a minority of organizations formed post-1960 offers the same infrastructure. Another particularly interesting finding is that of three organizations formed post-2000, none of them offer chapters. Considered with ***Figure 5-2*** showing material incentives by era of formation, the evidence shows that older organizations on average provide both more material and solidary incentives to their members.

Organization Size and Solidary Benefits

Once again, one can separate organizations by size to see variations in how incentives differ when organizations cater to a different number of members. Again, pure collective action theory would predict more benefits from larger organizations. ***Figure 5-6*** shows the result of separating organizations by quartiles based on membership size:

Figure 5-6



Group	Average Size
Bottom 25% (N=20)	1,868
25th-50th percentile (N=20)	5,410
50th-75th percentile (N=20)	12,357
Top 25% (N=21)	66,852

Unlike the pattern seen when analyzing material incentives in ***Figure 5-3***, larger organizations tend to be slightly more likely to offer state and local chapters, attempting to formalize solidary benefits through their hierarchy. This can be expected as larger organizations may find it difficult to sustain their higher numbers of membership without a more extensive network of state and local chapters to disperse administrative burdens and recruit members. But as ***Figure 5-6*** shows, there is no easily generalizeable pattern as organizations within the 25th to 50th percentile proved most likely to offer regional chapters apart from the national headquarters.

Intra-Specialty Competition and Variation in Solidary Benefits

Once again, as in the section on material incentives to begin this chapter, I provide this analysis in the Appendix in section A-5. While the results once again were overall inconclusive, some specialties respond to heightened competition for members in a manner consistent with expectation and some organizations appear not to respond noticeably to competition, offering no formal chapters at all. As before, this analysis suggests that specialties must be examined on a case by case basis to understand where some intra-specialty competition spurs more incentive generation while other cases show no such effect.

Alternative Conceptions of Solidary Benefits

While this thesis has presented the data of solidary benefits as political scientists such as Hayes (1986) conceive them through state and local chapters, ***Table 5-1*** presents ways in which interests in organized medicine may still offer solidary benefits outside of the more traditional local and state chapter metric:

Table 5-1

Other Types of Solidary Benefits	
Benefit	Organizations Offering Benefit (%)
Chance to Serve Committees or Special Interest Groups	85.19%
Social Networking Presence	75.31%
List-serves and Online Discussion Forums	62.96%
Mentorship Program	6.17%

As ***Table 5-1*** shows, eighty-five percent of organizations offer the opportunity for members to serve on informal committees or "special interest" groups where member join based on a common interest within practice. Each organization offering this incentive may differ in the

structure and format of these committees, but this strategy allows members to interact based on personal interests, even if these committees hold no power within organizational hierarchy.

Seventy-five percent of organizations reported a social networking presence through Twitter or Facebook. In an age of technology, this provides another method of member interaction outside of the more traditional political science literature. Similarly, nearly sixty-three percent of organizations reported having online forums for members to discuss controversies in practice or other topics of discussion. While mostly centered on clinical issues, I argue that one can consider this an effort to allow member interaction outside of formal state and local chapters.

Finally, five organizations (representing six percent of organizations) offer informal mentorship programs where new physicians are matched with more experienced doctors.

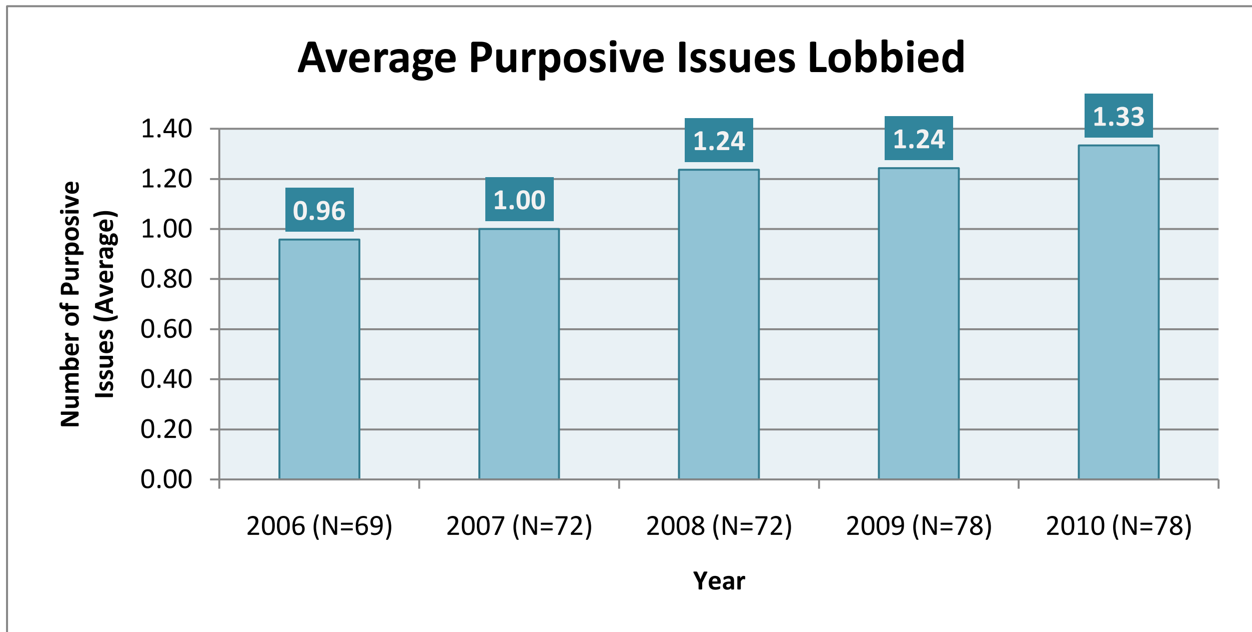
All of this suggests that while many organizations within organized medicine may be focused on practice-based, economic, or scientific pursuits on the whole, most organizations offer some type of initiative-based solidary benefits unlike more traditional interest groups in political science which may formalize member interaction.

Purposive Incentives in Organized Medicine

Thus far, I have examined the role of both material incentives and solidary incentives within organized medicine. Yet the third category of incentives described by Clark and Wilson (1961) include purposive incentives. These incentives include the intangible reward of fighting for a cause that has no direct return for the group or the members themselves. As mentioned in the methods section of this chapter, I operationalized this by examining the number of issues taken up by these organizations which represented no direct economic return for the members.

How many purposive issues do groups within organized medicine lobby over? ***Figure 5-7*** shows the breakdown across organizations by year, excluding those groups which did not lobby in a particular year:

Figure 5-7

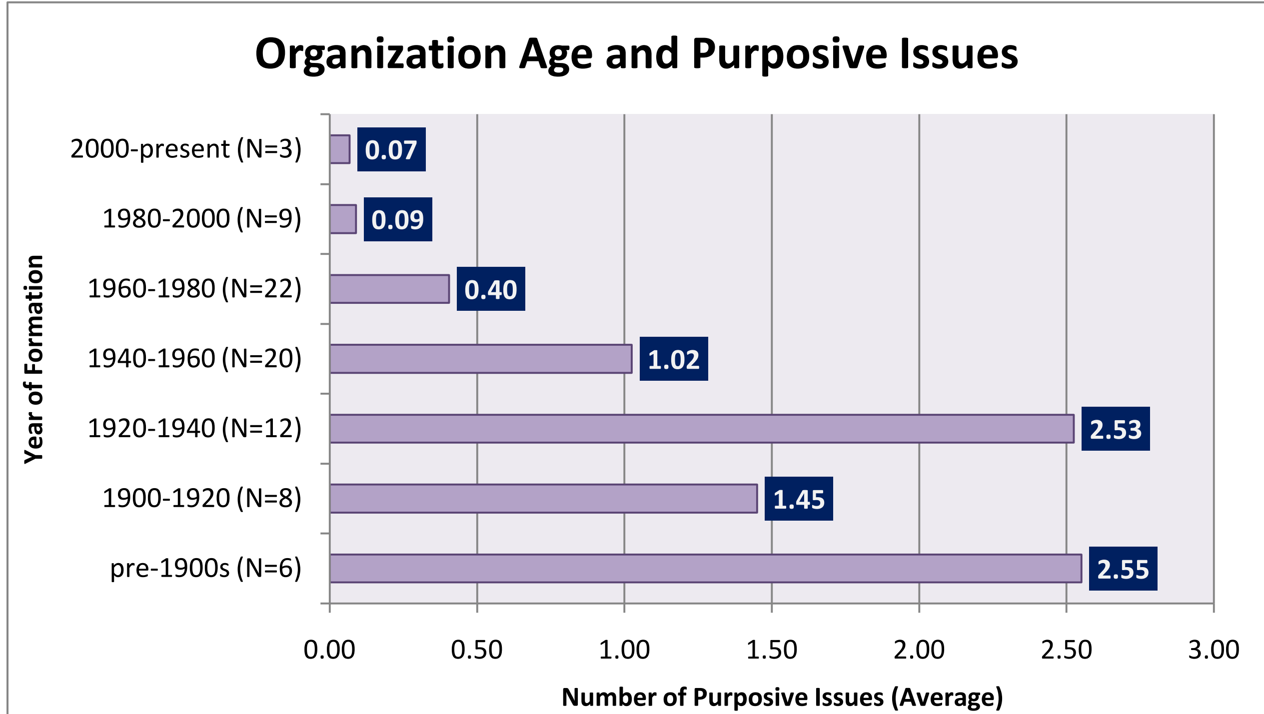


As ***Figure 5-7*** shows, organizations on average did little lobbying on purposive issues, around one issue per year. To put this into perspective, organizations lobbied for thirteen issues per year on average. Here again, the data was slightly skewed. Over sixty percent of organizations that reported their lobbying did not lobby for a single purposive issue at all. Therefore, one might wonder how variation might occur among these organizations.

Organizational Age and Variation in Purposive Benefits

In ***Figure 5-8***, I show how organizations varied in their lobbying over purposive issues. The numbers show that older organizations once again offered the most potential for purposive benefits in membership.

Figure 5-8



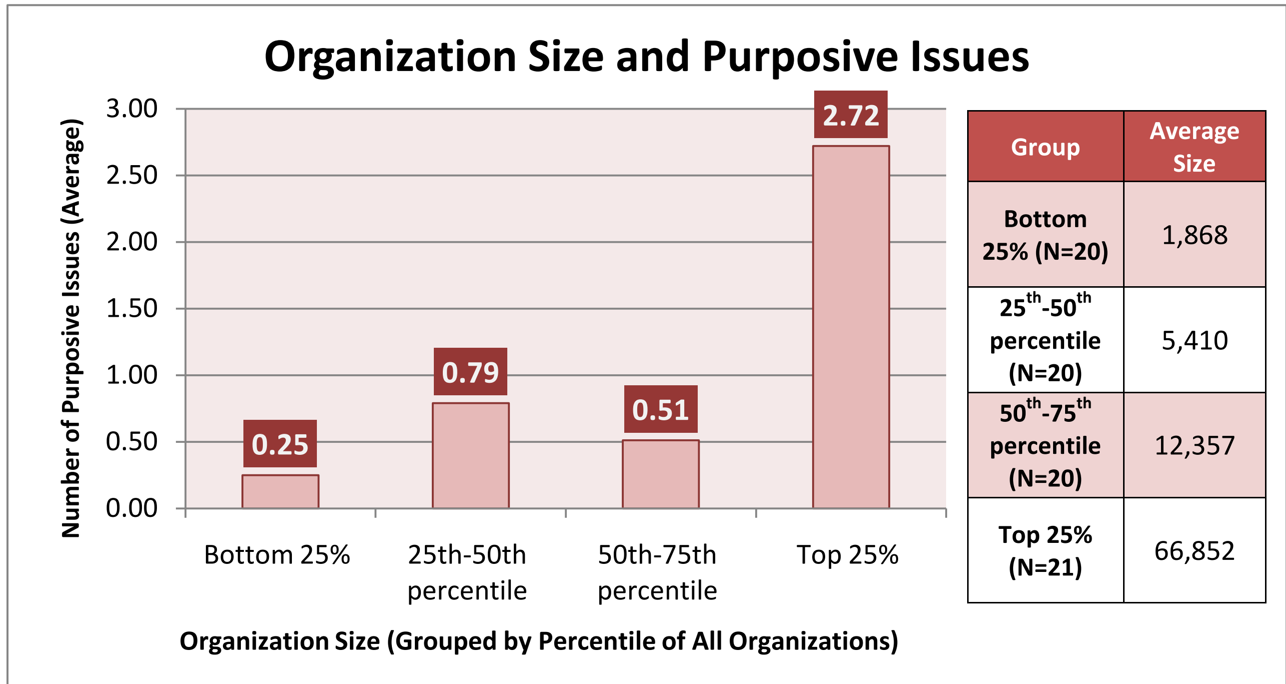
Consistent with both the analyses on material and solidary benefits, ***Figure 5-8*** shows that the organizations formed before the 1960s in an age of politicized healthcare with Medicare, gave more potential for purposive benefits for members. While there may be no particular connection to Medicare, the data thus far suggests that organizations may partially be a product of their time and that their strategies in incentivizing membership consistently differ when organizations are grouped by year of formation. Something about these older, more established organizations shows that they are more reliant on the traditional benefits envisioned by these incentive theorists writing in the 1960s.

Organizational Size and Variation in Purposive Benefits

In ***Figure 5-9***, I show how groups within organized medicine vary in the number of purposive issues based on the size in members. Once again, I separate organizations into four

distinct groups by quartiles and find that the largest organizations have the most purposive issues.

Figure 5-9



Group	Average Size
Bottom 25% (N=20)	1,868
25th-50th percentile (N=20)	5,410
50th-75th percentile (N=20)	12,357
Top 25% (N=21)	66,852

While again the relationship may not be perfectly linear, there appears a clear difference between the largest organizations and the smaller groups. The large groups proved to take on many more purposive issues altogether than any of the other groupings separated when by quartiles, as many five times more purposive issues than the 50th-75th percentile of groups by size and ten times as many as the bottom 25%. This suggests that while purposive issues may overall play a small role in most groups in organized medicine, the largest organizations do however take on supra-personal goals when they lobby.

Intra-Specialty Competition and Purposive Benefits

As in the previous two sections on material incentives and solidary incentives, I provide this analysis in the Appendix in section A-6. In this instance, I found again that each specialty

varies in its response to competition. However, for readers that do refer to this section, I note that the specialty of psychiatry was a particular outlier in that all of the organizations that catered to psychiatrists tended to lobby on more purposive issues than any other specialty in medicine.

Chapter Recap

As this chapter presents, groups within organized medicine do incentivize membership in a way consistent with incentive theory. By far, the most compelling reason for membership appears to be material incentives which give economic or monetary returns for members. Solidary benefits appear to play a small role within organized medicine as the majority of organizations offer no formal infrastructure for consistent member interaction. Purposive benefits also appear to have some contribution in these organizations, however with the majority of groups not lobbying for any purposive issues at all, it is unlikely to be the most important basis for membership. While the incentive systems recognized by Clark and Wilson (1961) all played some role in the approach to collective action problem, Olson's (1965) theory emphasizing material incentives seems most compelling within organized medicine.

In the additional analyses within this chapter, I find variations within organized medicine that may have some broader implications. First, I find that older organizations which pre-date the 1960s tend to offer more incentives for members. Meanwhile new age organizations approach collective action slightly differently in that they tend to rely less on the traditional incentives we have examined. This is surprising because if one looks back at Appendix A-2 again, it becomes apparent that every organization has some degree of competition with another more established group in order to attract members. Yet in response to this competition it is not the new

organizations which attempt to compensate with more member incentives but the older, more established groups.

Examining organizations by size was also telling as it shows that the top 25% of organizations grouped by size tend to offer fewer material incentives but more potential for solidary and purposive benefits than other groups might. The purposive issues were particularly telling as this suggests that organizations that house the largest number of American physicians also tend to be the ones seeking more supra-personal goals for the benefit of society or the patients they treat.

Finally, intra-specialty competition seemed to have no recognizable effect on any incentives. This analysis suggests that each specialty must be viewed on a case-by-case basis to understand how competition may have some relationship with the incentives offered.

Chapter 6: Organized Medicine by the Numbers

The following chapter focuses on the raw financial data provided by IRS Form 990s to test theories by Olson (1965) who argues for lobbying as a byproduct and Walker (1991) who argues that organizations rely on outside funding.

Chapter Methods

In this chapter, findings I present are based on the financial data of each organization mined from yearly filings of IRS Form 990s. These forms provide detailed accounts of the sources of functional revenue and expenses from year to year. Although returns for 2010 are not yet available at the time of this writing, I focus on the years 2006 through 2009. Given numbers in pure dollar amounts from these tax filings, I convert these to percentages and present them within this chapter. Using these figures, I break down both expenses and revenues to see whether Olson's and Walker's predictions hold true within organized medicine.

Examining Sources of Revenue within Organized Medicine

Chapter 2 already introduces two key theories which relate to activities of interest groups. Olson (1965) writes that professional organizations like the AMA focus on services foremost. These services, in tandem with member dues for organizational maintenance, should create the basis for membership and provide revenue for an organization to function. Meanwhile, Walker (1991) responds, portraying modern interest groups as less reliant on membership than Olson suggested. From his 1985 survey, he provides evidence that organizations have other ways to

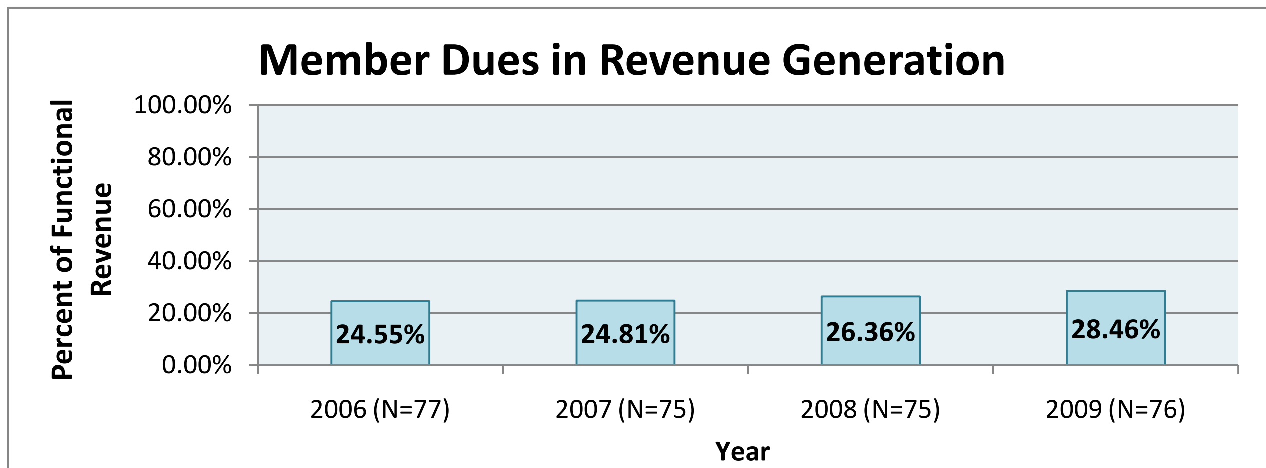
secure funding to focus on lobbying including four specific sources: government grants, patronage through donors, investments, and royalties.

If Olson is correct with regards to organized medicine, one should find that physician associations and specialty societies will attain most of their revenue from direct member dues and program service revenue generated from the sale of such items as journals and other services offered. The previous chapter described these program services in great detail; these are the same "selective material incentives" reported in Chapter 5. On the other hand, if Walker is correct, groups within organized medicine should focus less on the creation of material incentives and more on receiving revenue from other sources.

Member Dues and Services in Revenue Creation

First, I establish the role of direct member dues within the revenue of each organization. ***Figure 6-1*** shows each year between 2006 through 2009, showing the percentage of revenue generated from member dues alone among all organizations that chose to report this figure[12]:

Figure 6-1

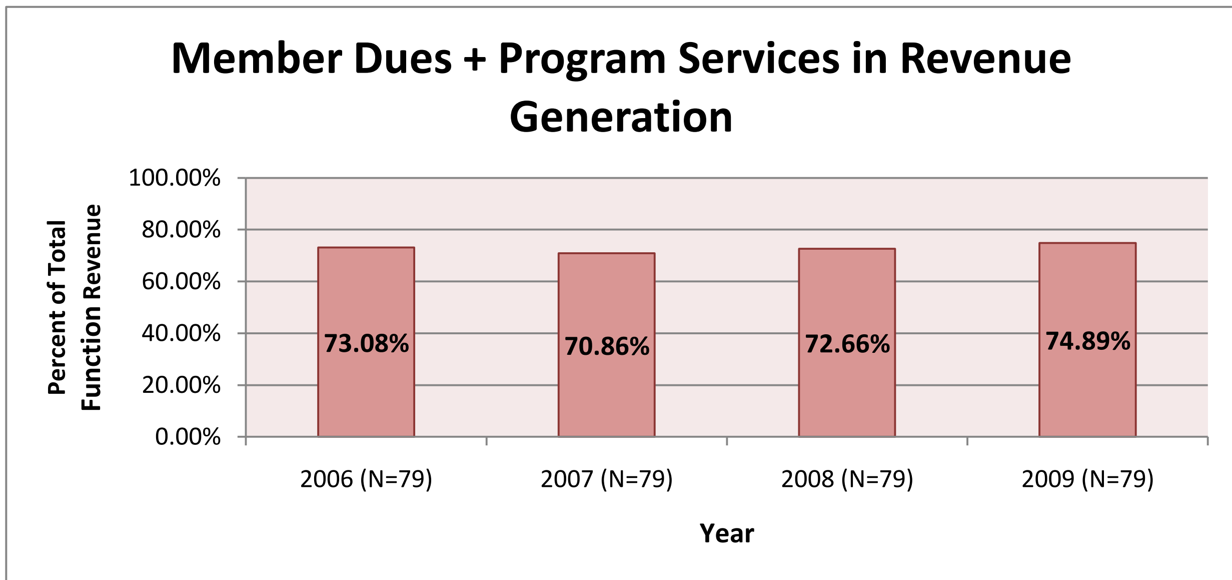


[12] Out of 81 total organizations which have been mentioned in this study, this and all following figures exclude any organizations which have missing information for that year. The limitation is that this produces slightly different year to year data, but as I make no specific conclusions based on year-to-year changes within membership-based revenue, I show the numbers as they are while noting a limitation.

Taken as a rough average across organizations within organized medicine which reported this data, one-fourth of organizational revenue comes directly from member dues. This shows that organizations are not completely unaccountable to members however it also proves that the majority of revenue comes outside of traditional yearly dues.

To test Olson's (1965) theory further, one must next observe program services and member dues together. Program service revenues include such funds generated from the sale of publications, educational materials, and other products. Without a member base to sell these products to, the organization would not be able to generate much demand for these services. And in the same circular manner, Olson (1965) argues that without these incentives, there would be no members. With both program services and member dues shown together one finds the following as depicted in ***Figure 6-2***:

Figure 6-2



As the preceding chart shows, over 70% of revenue originates from members and member-related services. At this juncture, I come across one instance where physician associations are an important exception to most interest group theories. As a result of the highly

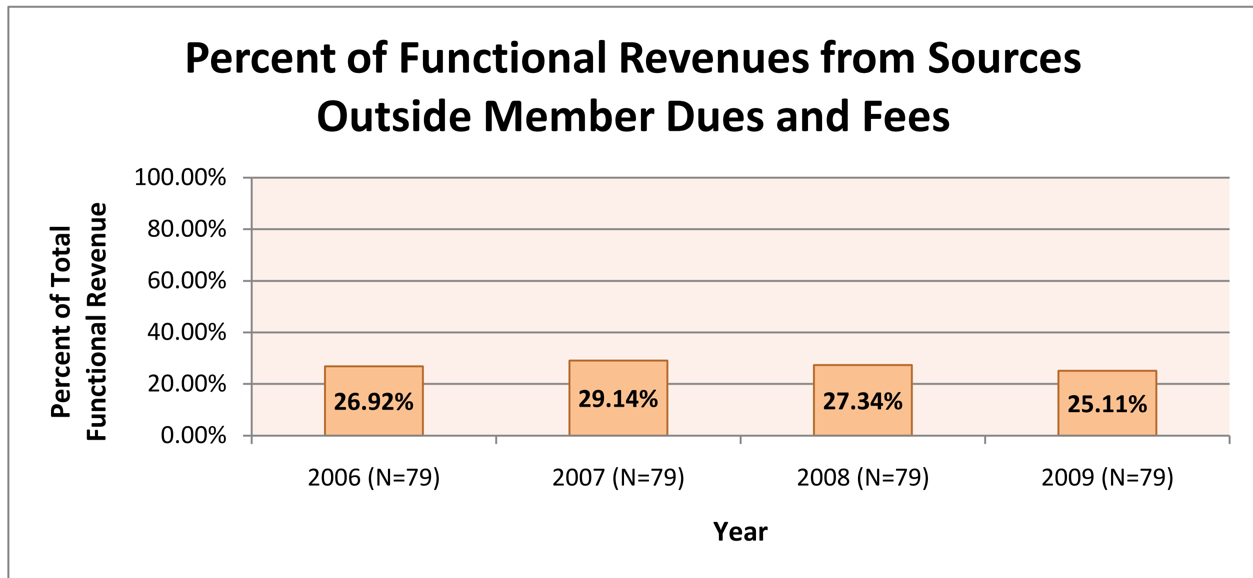
specialized constituency to which they care, physician associations cannot sell their products to simply any consumer in the market. Rather, these organizations derive much of their revenues with reliance on a highly specific subset of professionals that do find them useful (Heaney 2004). Therefore, one could argue that physician organizations are more reliant on those members for revenue than many of the organizations which Walker (1991) studied that have broader appeal.

Walker's Outside Sources of Funding

Walker's theory of outside funding merits attention as well. When organizations find ways to create revenue outside of reliance on members alone, Walker says that they have more leeway to pursue larger goals apart from pleasing the constituency through incentivizing membership. Could this be the case within organized medicine? ***Figure 6-3*** on the following page examines the percentage of organizational revenues generated from sources outside of dues and fees.

This figure shows that on average, groups within organized medicine may earn just as much revenue from outside sources as from annual member dues. In Walker's own dataset from 1985, the organizations he studied received 18.4 percent of their revenue from these outside sources with some receiving as much as 100% of revenue outside of the membership. This was enough for him to conclude that modern interest groups have sidestepped collective action problem by seeking alternative sources for revenue. One surprising finding is that organized medicine bests Walker's figure from 1985 as more than a quarter of revenue comes from such sources on average, however unlike Walker's interest groups, no organization within organized medicine received more than 65% of its revenue from the outside sources he identified.

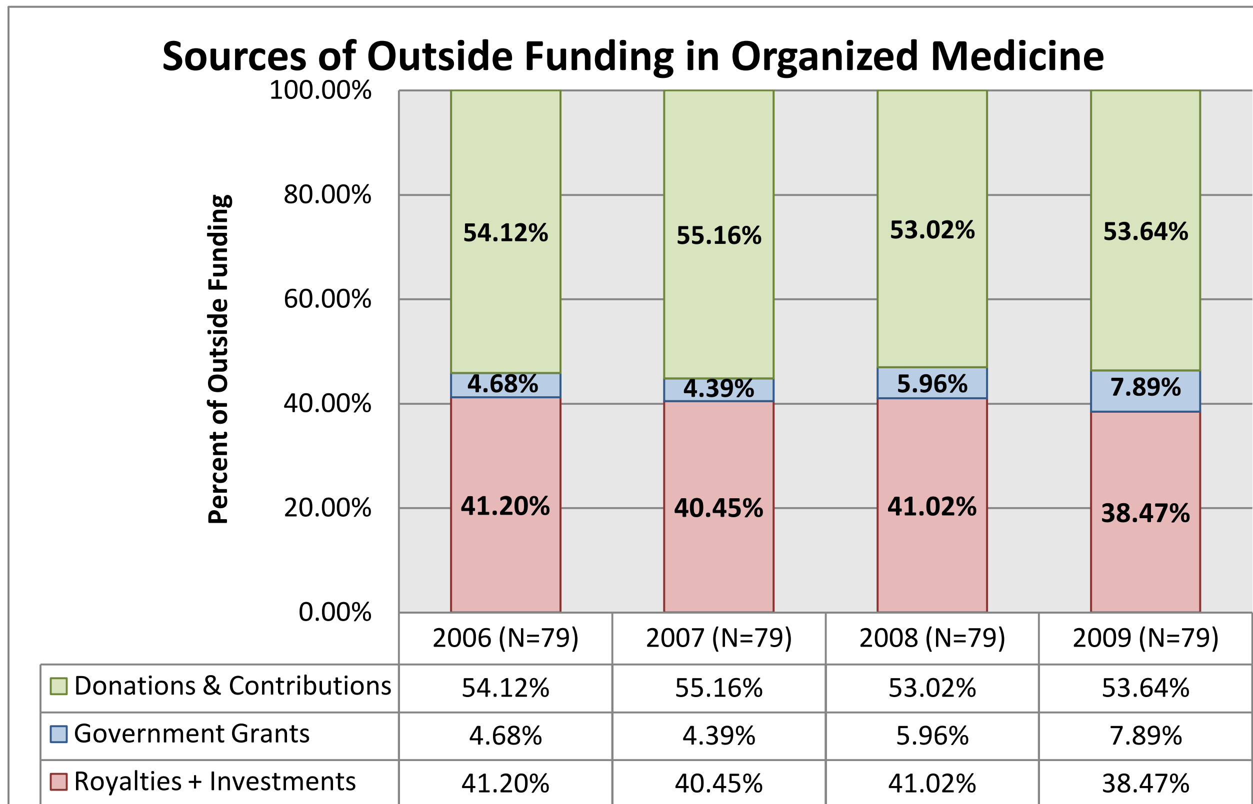
Figure 6-3



Cause for Concern?

As one finds that such a large percentage of organizational revenue comes outside of the membership, particular concerns arise with regards to medical ethics. Some pay particular attention to the ties of pharmaceutical industry to physicians as far back as the 1900s and some fear that they still play a large role in organized medicine (Stone 1997). Studies conducted on patient-pharmaceutical relationships do find that pharmaceutical companies attempt to influence prescribing practices by offering free drug samples, free trips to conferences, or other smaller gifts like meals to "buy goodwill" of physicians (Orlowski 1992; Waud 1992; Gibbons et al. 1998; Morgan et al. 2006). And as fears have reached lawmakers in 2010, Senator Charles Grassley (R-IA) requested 33 nationally-oriented health associations to make public disclosures of contributions they received, including any pharmaceuticals that may fund physician associations or specialty societies (Marrs et al. 2010). In ***Figure 6-4***, I examine these outside sources of funding as much as the Federal Form 990s provides a breakdown:

Figure 6-4



Walker (1991) particularly emphasized the role of patronage in the form of donations and contributions in interest groups, and as seen in ***Figure 6-4***, they play a notable role in generating "outside funding" here. This is most relevant to concerns of citizens and lawmakers like Grassley as fifteen percent of revenue comes from this category. The federal Form 990 does not require non-profit organizations to reveal where these donations come from, but perhaps more attention should be given to this to find out how much of these contributions come from wealthy donors or members already invested in the organization, as Walker observed in his groups. On the other hand, this money could come from more questionable links such as pharmaceutical companies.

Of course, organized medicine gains some of its revenue from other sources shown in ***Figure 6-4***. Royalties and investments are one such source, and they seem to play a larger role in organized medicine than the groups Walker studied. Although anomalous that he included them

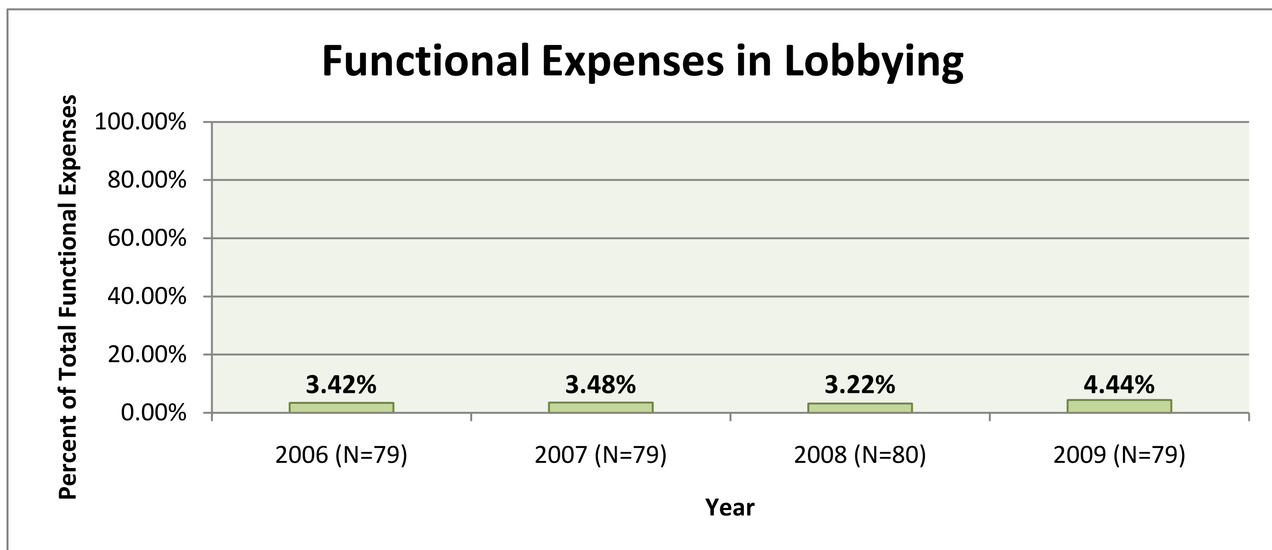
in his definition of "outside sources of funding", his groups in 1985 did not rely as heavily on this category as do physician associations and societies today. The final category of outside funding is government grants, but organized medicine relies least on this source of funding. Reported as a total of all functional revenue, government grant money gives a little over one percent of revenue on average to these groups.

Examining Organizational Expenditures and the Role of Lobbying

While the evidence on organizational funding suggests that Walker may be correct about outside sources of revenue playing some role, I now shift the attention away from organizational revenue generation towards group expenditures.

Another source of conflict between the theories of Walker and Olson regard the role of lobbying. Does lobbying play a secondary role or a byproduct, as Olson believed? Or does lobbying play the most significant role as Walker suggested two decades later? ***Figure 6-5*** explores this in a fairly startling finding within organized medicine

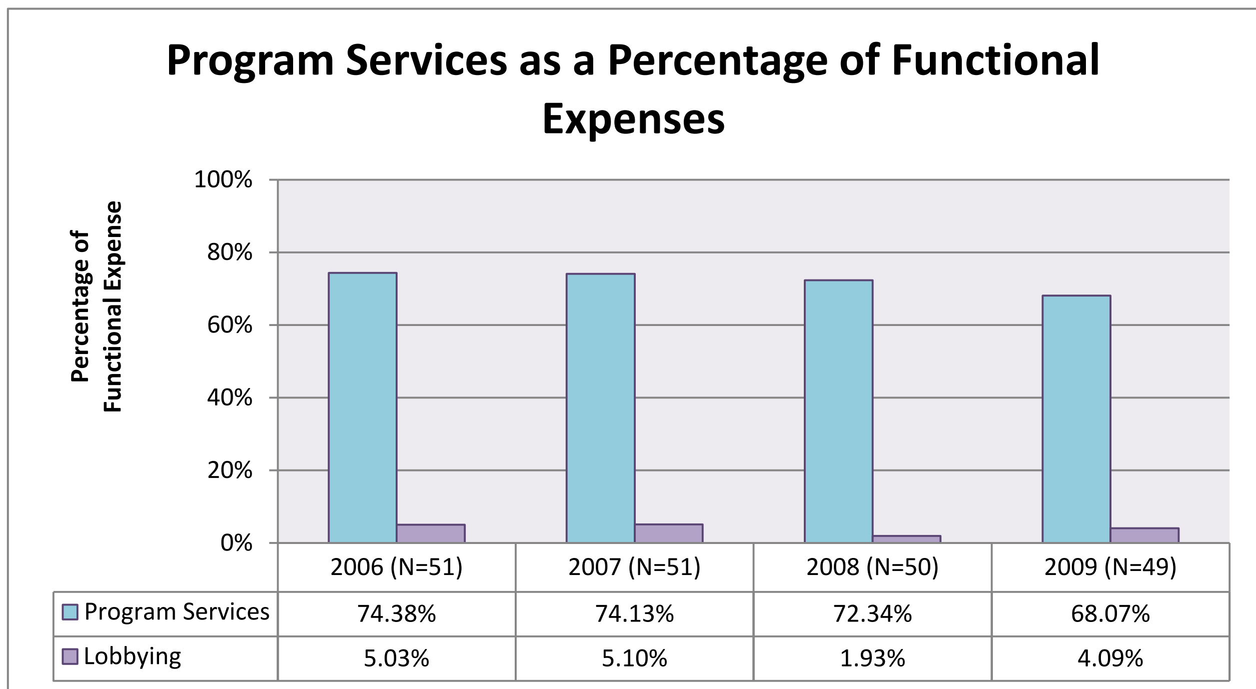
Figure 6-5



As this ***Figure 6-5*** suggests, lobbying on average plays a much smaller role than one would expect in most interest groups. With around just four percent of expenses going towards policy activity on average, these organizations have priorities outside of lobbying alone. The biggest spender on lobbying was far and away the American Medical Association at over $17 million per year, but even this represents around eight percent of the organization's total expenditures per year.

If organizations are not spending most of their money to lobby, where do they spend their revenues? Although I found more limited data to answer this question, I nonetheless present ***Figure 6-6*** which shows data on fifty-one organizations that reported detailed expenditure data:

Figure 6-6



	2006 (N=51)	2007 (N=51)	2008 (N=50)	2009 (N=49)
Program Services	74.38%	74.13%	72.34%	68.07%
Lobbying	5.03%	5.10%	1.93%	4.09%

The data is imperfect as nearly forty percent of the total 81 organizations did not report the breakdown of program service expenditures, although it does provide some insight into the remaining organizations that provided more complete data. ***Figure 6-6*** suggests a tremendous

disparity between funds spent on lobbying and those spent on servicing the incentives that draw in members. For the remaining thirty organizations which did not report expenditures on program services, their lobbying patterns were not wholly inconsistent with these 51 organizations shown here. Thus if data for the remaining organizations were somehow obtained, the relationship between program services trumping lobbying expenditures should still hold.

Together, ***Figure 6-5*** and the supplement of ***Figure 6-6*** provide fairly compelling evidence that organized medicine exhibits lobbying as a byproduct as per Olson (1965). If organized medicine generally lobbied as its primary goal, one would find that a greater percentage of funds would be spent towards this. Instead, organizations exhibit a consistent pattern for these four consecutive years where around three to four percent of their budgets on average go towards lobbying, while as much as twenty times this amount goes to service the selective material incentives examined in Chapter 5.

Walker's Outside Funding Revisited

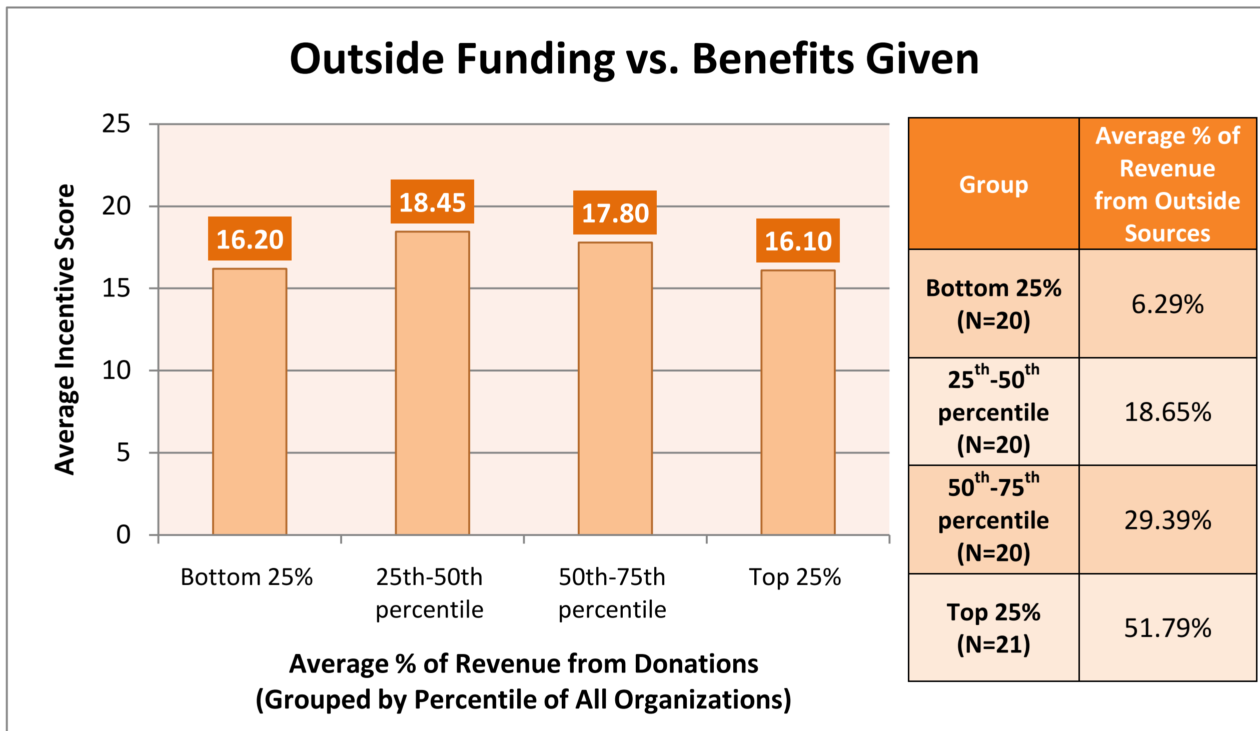
While the evidence presented supports Olson's by-product theory of lobbying, this chapter also previously confirmed Walker's theory that outside funding plays some role in modern organizations. Walker's original analysis focused on four types of outside funding that comprised of royalties, investments, government grants, and patronage in the form of contributions.

But does this outside funding have any impact on organizational priorities and expenditures as Walker predicted? If Walker were correct, one should find that groups within organized medicine provide fewer incentives if they've attained more outside funds. Walker is

unequivocal about this relationship as he states that patrons who donate seek the attainment of collective goods and therefore act a source of pressure guiding an organization towards lobbying.

Figure 6-7 represents the relationship we seek to examine and as the data shows, organizations with more outside funding do not offer significantly fewer incentives. In some cases, they may even offer *more* selective material incentives:

Figure 6-7

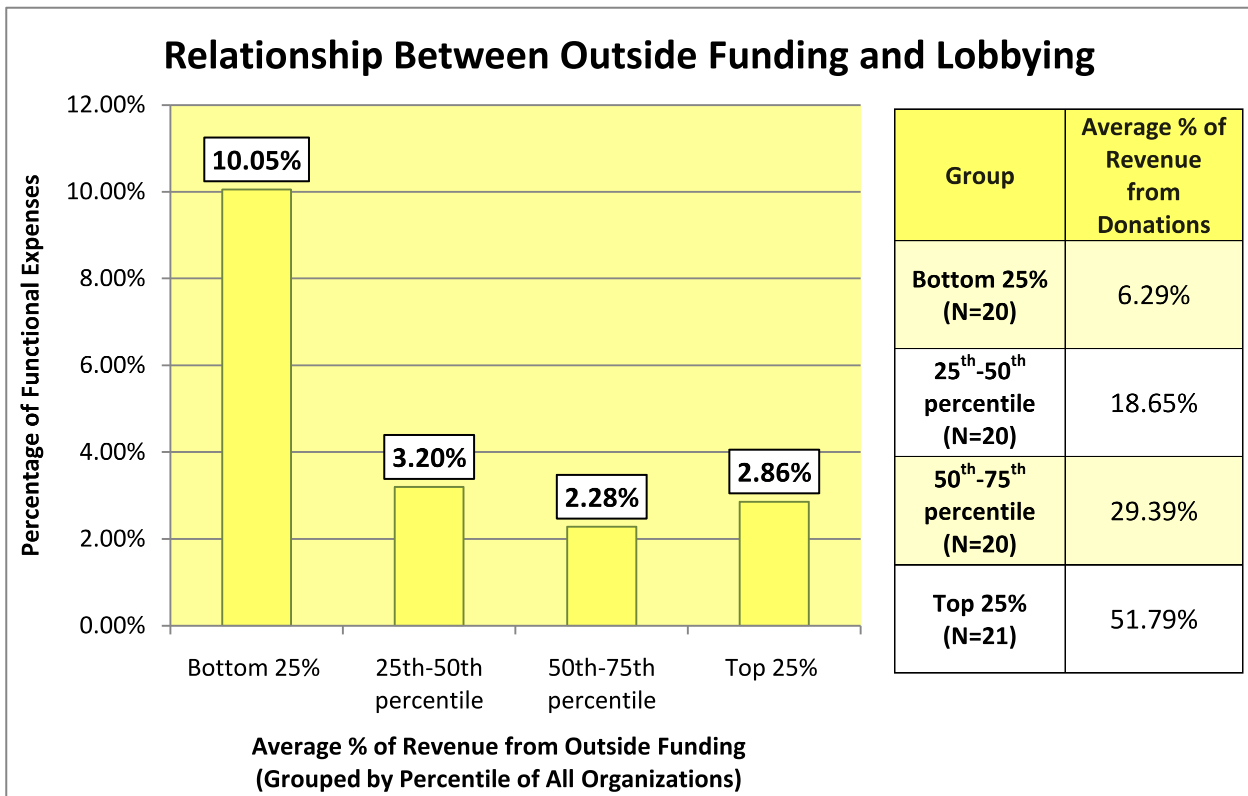


Group	Average % of Revenue from Outside Sources
Bottom 25% (N=20)	6.29%
25th-50th percentile (N=20)	18.65%
50th-75th percentile (N=20)	29.39%
Top 25% (N=21)	51.79%

Figure 6-7 shows that while the bottom 50% of organizations receiving revenue from donations and contributions gave slightly more material benefits than groups in the top 50%, the relationship was not necessarily linear. This suggests that while outside funding may have some effect on organizational priorities in some way, this does translate to a recognizable pattern and that organizations in the middle groups tended to offer the most incentives.

Of course, another way to test Walker's theory on the role of outside funding would be to find the relationship between outside funding and the role of lobbying in the organization. Walker suggested that the main impact of outside funding is that organizations have more opportunity to focus on collective goods. ***Figure 6-8*** shows the result of separating groups by quartiles based on the revenue obtained from outside sources.

Figure 6-8



Group	Average % of Revenue from Donations
Bottom 25% (N=20)	6.29%
25th-50th percentile (N=20)	18.65%
50th-75th percentile (N=20)	29.39%
Top 25% (N=21)	51.79%

Figure 6-8 provides the final confirmation that Walker's theory on outside funding may not be completely applicable to organized medicine. Although organizations gain more of their revenue from sources outside of the membership than what Walker showed with his 1985 survey data, these organizations do not use this outside funding as a means to sidestep collective action problem in the way Walker predicts.

Why is organized medicine the exception to Walker's prediction? There may be many possible reasons. For one, Walker spoke of the role of wealthy patrons who donated to organizations and put pressure on organizations to "get things done" via lobbying. In organized medicine, it may well be that the donors are not seeking more lobbying when they donate. With sources such as pharmaceutical companies, for example, the patrons who give may not have any interest at all in collective goods. Secondly, another reason why organized medicine is an exception to Walker's prediction is the way these groups attain outside funding. While we saw earlier that most funding comes from donations and contributions, a sizeable portion of outside funding also comes from royalties and investments of these organizations. This may be more relevant in 2010 than it was in the 1980s when groups received most "outside funding" intuitively from sources that were outside the organization. Thus as physician associations and societies have found ways to raise revenue internally, they may not necessarily feel the pressure of wealthy patrons seeking more achievements via the lobbying arm of the organization.

Chapter Recap

As the financial data shows, groups within organized medicine appear to lobby as a byproduct of their other functions as professional societies. While they have found ways to raise revenues outside of member dues alone and even exceed the totals of such outside funding as Walker predicted in 1985, they do not necessarily use this money to spend more on lobbying. Therefore, it is reasonable to conclude that Olson's Byproduct theory is most applicable to organized medicine and that most money is spent towards servicing activities and benefits sold to members to gain a captive membership and gain more revenues.

Chapter 7: Conclusion

This chapter finishes with a concluding analysis on the findings within this thesis, the study limitations, and future topics for research.

How do groups within organized medicine approach the collective action problem as they lobby? As this thesis shows, they focus heavily on material incentives towards membership and lobby as a Byproduct of these incentives that are the basis for membership. In addition, some organizations employ varying levels of solidary and purposive benefits to attract members. And meanwhile, organizations attain a significant amount of funding outside of their membership alone but they do not necessarily use this extra funding to lobby for collective goods.

Concluding Thoughts on Fractionated Politics

One major goal of this thesis was to describe the lobbying efforts of organizations which have branched out of the physician political movement of the 20th century to lobby on their own rather than to continue following the AMA. But as Chapter 6 shows, physician associations may not necessarily be politically-inclined in the traditional way other interests are. We find that the politics of organized medicine follows more closely in the traditions of the old political science literature such as Olson (1965) would suggest, instead of resembling the more modern theories of King & Walker (1992) and Walker (1991). While Walker's predictions based on his 1985 survey may be a useful way to describe most contemporary interest groups, they are not particularly relevant when viewing *these* 81 organizations that mostly emphasize scientific pursuits or the professional needs of members.

A more compelling story within organized medicine is that over time, groups have formed for reasons other than ideology or political views. Instead, as organizations have arisen to out of the increasing complexity of medicine and medical specialization, they have simultaneously encountered a government more inclined towards regulating health policy and more involved in health decisions through programs like Medicare, Medicaid, Veteran's Affairs Healthcare Systems, and CHIP. Once they form for reasons related to their more scientific pursuits, it seems natural that these groups then lobby as a byproduct of other goals. This may explain why one sees eminent scholars such as Starr in 1982 spending little time describing the political activity of specialty societies and associations, when—as Chapter 4 shows—nearly ninety percent of them were already in existence at the time he wrote.

In retrospect, the story behind organized medicine differs from the one Walker portrays in 1985. He emphasized the role of policy entrepreneurs who come from outside an organization to aid collective goals, but one finds that groups within medicine have paid particular attention to needs of members and organize from within. Therefore, the groups in this area of healthcare have formed for reasons other than ones Walker identified in his writing.

Drastic Decline of the AMA? Thoughts on the Future of Physician Organization

In Chapter 3, I described the AMA of old through writing of scholars such as Peterson (1993, 2001), Olson (1965), Starr (1982), Stevens (1991; 2001), and Rothman (1993) among others. But has the AMA faced such a precipitous decline as some argue? (See Dorin 2007).

The answer depends on one's perspective. For example, the AMA no longer wields the coercive powers of the past which allowed it to control the physician workforce and industry before Supreme Court and FTC decisions enforced anti-trust restrictions. The AMA also no

longer serves as the sole source of healthcare lobbying or political influence in Washington, DC as we've come to an age of "health pluralism". In addition to physicians, one finds the lobbying efforts of pharmaceutical companies, insurers, hospitals and nursing homes, other non-medical health professionals, non-profit research foundations, businesses, and managed care organizations such as HMOs. And of course from an organizational standpoint, the AMA no longer holds the allegiance of most American physicians and has suffered the very same decline in membership that its leaders foresaw nearly three decades ago (Starr 1982).

On the other hand, the AMA is not completely irrelevant in healthcare politics today. When President Obama convinced the Association to support healthcare reform in 2009 and 2010, critics hailed it as a triumph to bring the organization towards the cause of health reform for the first time (Oberlander 2010). Additionally, 56 of the 81 organizations I studied in this thesis, currently hold one seat in the AMA House of Delegates and while this may not be indicative of any significant organizational involvement, it may still be symbolic of the fact that these groups recognize that the AMA has some relevant role in healthcare. In my data on the lobbying totals and financial data, I found that on average, the AMA spent around eight percent of its budget towards lobbying but this translated to over seventeen million dollars per year from 2006 through 2010. This easily dwarfed the lobbying of the next closest organization, the American Academy of Family Physicians, which spent on average $2.6 million per year on lobbying over that same time frame.

Looking to the future however, specialization seems only to be on the rise and the disparity in pay and work hours may only contribute further to the primary care shortage. The AMA which has transitioned towards serving the general practitioner may face problems sustaining its numbers without a change in organizational strategy. Today, it already attains

nearly fifty percent of its revenue from the outside sources Walker mentioned. The Association claims all of this money comes from royalties and investments, and one wonders what may happen next if the organization faces additional decline in the primary care workforce to which it caters.

Relevance to Medical Care and the Healthcare System

To the average healthcare consumer reading an analysis such as this, it may not be readily apparent how a collective action framework may of benefit. I argue, conversely, that the collective action framework provides much insight into the organizations that speak on behalf of American doctors in Washington. As David Mechanic puts it eloquently, physicians “control vast sums of other people’s money with every health decision” and should therefore receive more attention from the standpoint of political organization (Mechanic 1991).

Regarding healthcare costs, this research makes clear the problem Congress could not see in the 1980s: these specialty societies should not be seen as groups organized around regulating practice or prices. Instead much of their patterns of activity and the services they offer suggest that they organize largely around material benefits and focus on the particular scientific, professional, and career goals of each member.

I argue that looking at incentive systems in organizations also clarifies that these associations are not traditional interest groups. For those who wonder what role physicians may have in future healthcare reforms, it may be difficult to tell but the limited amount that these groups spend out of their budgets shows that they are not purely political. The groups that represent American physicians are more like unions without collective bargaining rights that will lobby on such issues that affect practice. In the meantime, organized medicine lobbies almost

every year to Congress to give physicians collective bargaining rights. If their efforts prove successful, they may resemble unions even more.

Regarding the role of physicians in the public sphere, this data shows that while physicians have much technical expertise to be involved in public health initiatives, much of their current lobbying focuses on issues regarding funding and government programs. This is not entirely problematic for the average consumer as many of these propositions become win-win. More research sought by oncologists could one day fund “the cure for cancer” while other pursuits such as maintaining funding for community clinics or setting up a national trauma network will still benefit patients in addition to the physicians in those practice settings. If trends continue as they have been from 2006 through 2010, physicians may have a limited role other than to make yearly suggestions on funding by the federal government. But there is still encouraging news as the largest organizations in organized medicine tend to take on more purposive issues for the benefit of society.

Finally, within the medical community, much has been made about the impacts of specialization for the delivery of health services. But as this update to the organized medicine literature shows, there are also clear political ramifications to these medical advancements. No longer does one find an umbrella organization such as the AMA of old to bridge both concerns of practitioners and professional lobbying efforts. Instead, one large sum towards lobbying originates from the AMA and the rest of lobbying efforts are divided amongst 80 other organizations with varying degrees of policy involvement.

What might future physician associations and medical societies look like when they join organized medicine by lobbying in Washington, DC? If the pattern holds, future groups will likely form from some advancement in medical specialization. Once groups have become

established, they may lobby as a byproduct to their scientific and professional goals. Additionally, they may not spend much time incentivizing membership as observed in the older organizations. Unless any remarkable developments occur, there may be little to no coordination within specialties and multiple organizations may spring up only to lay parallel claims to the same constituency of physicians. If correct, this prediction may describe the new paradigm of organized medicine in age of interest proliferation. What remains to be seen is if such developments may be helpful or harmful as the government tries to reform the healthcare system and gets more involved in health services with each passing decade.

Study Limitations

In the previous six chapters of this text, I have attempted to represent all study limitations as soon as I have recognized them. However in this section, I focus on overarching limitations within this thesis. Overall, the main shortfall may be the extensive reliance on self reported numbers presented throughout this thesis.

In Chapter 5, the incentive data generated on incentives came directly from any information presented in Federal Form 990s and mostly from organizational websites. While the incentives described in these websites was indeed extensive, I do not discount the possibility that other incentives may be offered to members which are not publicized by these organizations. I do argue on the other hand that organizations that offer such incentives but do not market them in any way to potential members would likely find it difficult to leverage these incentives to induce membership. Throughout this thesis, I have made the assumption that any incentives worth mentioning by these organizations have already been mentioned somewhere in the organization's web-presence. But in the case that organizations do offer other benefits and rely purely on word

of mouth for dissemination of this information, my study would not recognize or describe these particular benefits for members.

In Chapter 6, I rely on the financial data from a mix of lobbying expenditures reported by the Center for Responsive Politics and each organization's federal Form 990s from 2006 through 2009. I acknowledge that organizations may easily report inaccurate numbers. This becomes particularly problematic with the lobbying data, where interest groups routinely underreport their lobbying expenditures. Nonetheless, I use the numbers shown by the Center for Responsive politics and on the Form 990s with a good faith assumption that they are mostly accurate. Of course, if organizations were not completely forthright in their financial or lobbying data, given that these figures are reported annually to the federal government at risk of auditing, I trust that organizations would have been no more honest when the stakes are much lower in interviews as Walker conducted in 1985.

Future Topics for Research

While this study focuses largely on collective action theories and applies them to organized medicine, several other key topics of research could supplement this work and contribute towards a greater understanding of organized medicine.

In Chapter 5, I present data regarding the expressive benefits offered by the 81 groups within organized medicine. Within this analysis, I rely heavily on OpenSecrets lobbying profile of these organizations. However, how might these groups interact in the policy field when they lobby? Do organizations coordinate efforts to get what they want? Hula (1999) would suggest so, as an adaptation to a crowded policy field. On the other hand, scholars such as Brown (1990) argue that interest group proliferation within a policy domain has the opposite effect as

organizations tend to carve out special "issue niches" for themselves and focus on ever-narrower legislative provisions so as to minimize conflict with other interests. The next logical step would be to examine which proves most accurate in physician political organization.

An additional line of inquiry is more investigation into the sources of "outside funding" presented in Chapter 6. Though IRS Form 990s show the amount of money coming from donor contributions, there is ambiguity as to who provides these donations that constitute, on average, 15% of organized medicine's organizational revenues. Are they simply from wealthy member donors? Or might there be closer links to other groups such as the pharmaceutical industry? The answer may be useful with growing concerns in medical ethics.

Third, while I have focus extensively on the policy activity of lobbying, an argument can also be made about more study on campaign contributions. What are the giving patterns of these organizations, and to whom to do they reach out in Congress? These questions deserve more attention as one begins to elucidate the political behavior of organized medicine. Gutermuth (1999) as well as Wilkerson & Carrell (1999) studied this question with regards to AMPAC, the AMA Political Action Committee, however given the crowded field of actors within organized medicine alone, there may be more to the story than the AMA alone.

Finally, I suggest that while this thesis is a starting point for further study on physician organization, the study only considers the importance of federal lobbying. More attention should be given to lobbying and physician organization on a state level, where individual states both set standards for licensure of professionals and also determine insurance policy standards. Much like physicians lobby the federal government to reimburse new procedures and treatments through Medicare, I believe the same type of involvement may occur at the state level where legislatures have power over which services are covered by all insurers within state borders.

APPENDIX

A-1: List of Medical Specialties

A list of 26 recognized medical specialties and some of the subspecialties within them. Note: this list was compiled using lists from the three major American licensing boards: American Board of Medical Specialties (ABMS), American Association of Physician Specialists (AAPS), and American Osteopathic Association Bureau of Osteopathic Specialists (AOABS)

1. Allergy and Immunology

2. Anesthesiology

- i. Critical Care Medicine
- ii. Hospice and Palliative Medicine
- iii. Pain Medicine

3. Colon and Rectal Surgery

4. Dermatology

- i. Clinical and Laboratory Dermatological Immunology
- ii. Dermatopathology
- iii. Pediatric Dermatology

5. Emergency Medicine

- i. Emergency Medical Services
- ii. Hospice and Palliative Medicine
- iii. Medical Toxicology
- iv. Pediatric Emergency Medicine
- v. Sports Medicine
- vi. Undersea and Hyperbaric Medicine

6. Family Medicine

- i. Adolescent Medicine
- ii. Geriatric Medicine
- iii. Hospice and Palliative Medicine
- iv. Sleep Medicine
- v. Sports Medicine

7. Internal Medicine

- i. Adolescent Medicine
- ii. Advanced Heart Failure and Transplant Cardiology
- iii. Cardiovascular Disease
- iv. Clinical Cardiac Electrophysiology
- v. Critical Care Medicine
- vi. Endocrinology, Diabetes, and Metabolism
- vii. Gastroenterology
- viii. Geriatric Medicine
- ix. Hematology
- x. Hospice and Palliative Medicine
- xii. Interventional Cardiology
- xiii. Medical Oncology
- xiv. Nephrology
- xv. Pulmonary Disease
- xvi. Rheumatology
- xvii. Sleep Medicine
- xviii. Sports Medicine
- xix. Transplant Hepatology
- xx. Hospital Medicine

8. Medical Genetics i. Molecular Genetic Pathology ii. Medical Biochemical Genetics **9. Neurological Surgery** **10. Neurology** **11. Nuclear Medicine** **12. Obstetrics and Gynecology** i. Critical Care Medicine ii. Gynecology Oncology iii. Hospice and Palliative Medicine iv. Maternal and Fetal Medicine v. Reproductive Endocrinology/Infertility **13. Ophthalmology**	**17. Pediatrics** i. Adolescent Medicine ii. Child Abuse Pediatrics iii. Developmental Behavioral Pediatrics iv. Hospice and Palliative Medicine v. Medical Toxicology vi. Neonatal-Perinatal Medicine vii. Neurodevelopmental Disabilities viii. Pediatric Cardiology ix. Pediatric Critical Care Medicine x. Pediatric Emergency Medicine xi. Pediatric Endocrinology xii. Pediatric Gastroenterology
14. Orthopedic Surgery i. Orthopedic Sports Medicine ii. Surgery of the Hand	**18. Plastic Surgery** i. Plastic Surgery Within Head and Neck ii. Surgery of the Hand
15. Otolaryngology (ENT) i. Neurotology ii. Pediatric Otolaryngology iii. Plastic Surgery Within Head and Neck iv. Sleep Medicine **16. Pathology** i. Blood Banking/Transfusion Medicine ii. Cytopathology iii. Dermatopathology iv. Neuropathology v. Chemical Pathology vi. Forensic Pathology vii Hematological Pathology viii. Medical Microbiology Pathology ix. Molecular Genetic Pathology x. Pediatric Pathology	**19. Preventive Medicine (Includes Aerospace, Occupational, Public Health Medicine)** i. Medical Toxicology ii. Undersea and Hyperbaric Medicine **20. Psychiatry and Neurology (Includes Psychiatrists and Neurologists)** i. Addiction Psychiatry ii. Child and Adolescent Psychiatry iii. Clinical Neurophysiology iv. Epilepsy v. Forensic Psychiatry vi. Geriatric Psychiatry vii. Hospice and Palliative Medicine viii. Neurodevelopmental Disabilities ix. Neuromuscular Medicine x. Pain Medicine xi. Psychosomatic Medicine xii. Sleep Medicine xiii. Vascular Neurology

21. Radiology (Includes Diagnostic Radiology, Radiation Oncology, Radiological Physics)
i. Hospice and Palliative Medicine ii. Neuroradiology iii. Nuclear Radiology iv. Pediatric Radiology v. Vascular and Interventional Radiology
22. Surgery (Includes Surgery and Vascular Surgery) i. Hospice and Palliative Medicine ii. Pediatric Surgery iii. Surgery of the Hand iv. Surgical Critical Care
23. Radiation Oncology
24. General Surgery (Includes Surgery and Vascular Surgery) i. Hospice and Palliative Medicine ii. Pediatric Surgery iii. Surgery of the Hand iv. Surgical Critical Care
25. Thoracic Surgery i. Congenital Cardiac Surgery
26. Urology i. Pediatric Urology

A-2: List of Organizations in Organized Medicine

A list of 81 organizations within organized medicine, including year of formation, size and the primary constituencies which they serve. If applicable, I have also included any subspecialties that may be prominently featured. Of course, some organizations feature overlap of constituencies.

Organization	Year of Formation	Members	Specialty	Subspecialty	Website
Alliance of Specialty Medicine	2003	200,000	All Specialists		www.specialtydocs.org/
American Academy of Child & Adolescent Psychiatry	1953	7,500	Psychiatry	Pediatric	http://www.cardiologycaa.com/
American Academy of Cosmetic Surgery	1985	1,800	Surgery	Otolaryngology, Plastic and Reconstructive Surgery, Dermatology, Obstetrics/Gynecology, General Surgery, Ophthalmology and Oral and Maxillofacial Surgery	www.aspneph.com/
American Academy of Dermatology	1938	16,000	Dermatology		www.jcaai.org/
American Academy of Family Physicians	1947	94,600	Internal Medicine	Family Physicians	www.asipp.org/
American Academy of Neurology	1948	22,500	Neurology		www.acep.org/
American Academy of Ophthalmology	1896	7,000	Ophthalmology		www.acro.org/
American Academy of Orthopaedic Surgeons	1933	36,000	Orthopedic Surgery		www.vascularweb.org/
American Academy of Otolaryngic Allergy	1941	2,700	Otolaryngology		www.spine.org/
American Academy of Otolaryngology- Head and Neck Surgery	1896	12,000	Otolaryngology		www.ama-assn.org/
American Academy of Pediatrics	1930	60,000	Pediatrics		www.entnet.org/
American Academy of Physical Medicine and Rehab	1930	7,500	Physical Med & Rehab		www.ooss.org/
American Association for the Study of Liver Diseases	1950	7,000	Internal Medicine	Hepatology	www.aans.org/
American Association for Thoracic Surgery	1917	1,200	Thoracic Surgery		www.cns.org/
American Association of Clinical Endocrinologists	1991	6,000	Internal Medicine	Endocrinology	www.acg.gi.org/
American Association of Clinical Urologists	1968	24,000	Urology		www.sts.org/
American Association of Geriatric Psychiatry	1978	2,000	Psychiatry	Geriatrics	www.a-s-t.org/
American Association of Neurological Surgeons	1931	8,000	Neurology		www.aagpgpa.org/
American College of Cardiology	1949	39,000	Internal Medicine	Cardiology	www.asahq.org/
American College of Chest Physicians	1935	17800	Internal Medicine	Critical Care, Pulmonology	www.astro.org/

American College of Emergency Physicians	1968	28,000	Emergency Medicine		www.scct.org/
American College of Gastroenterology	1932	11,000	Internal Medicine	Gastroenterology	www.asts.org/
American College of Obstetricians & Gynecologists (American Congress of Obstetricians and Gynecologists)	1951	52,000	Obstetrics & Gynecology		www.sgim.org/
American College of Occupational and Environmental Medicine	1916	4,500	Preventive Medicine	Occupational Medicine	www.astmh.org
American College of Physicians	1915	130,000	All Specialties		www.acc.org
American College of Preventive Medicine	1954	2,000	Preventive Medicine		www.aafp.org
American College of Radiation Oncology	1958	10,000	Radiology	Radiation Oncology	www.aad.org
American College of Radiology	1923	34,000	Radiology		www.auanet.org/
American College of Rheumatology	1934	8,439	Internal Medicine	Rheumatology	www.smfm.org/
American College of Sports Medicine	1954	20,000	Physical Med & Rehab	Sports Medicine	www.naspghan.org/
American College of Surgeons	1913	77,000	Surgery		www.acr.org/
American Gastroenterological Association	1897	17,000	Internal Medicine	Gastroenterology	www.sgo.org/
American Geriatrics Society	1942	6,000	Family Medicine	Geriatrics	www.gastro.org/
American Medical Association	1847	240,000	All Doctors		www.renalmd.org/
American Osteopathic Association	1897	70,000	N/A		www.ascrs.org/
American Psychiatric Association	1844	38,000	Psychiatry		www.aao.org/
American Society for Clinical Pathology	1922	130,000	Pathology		www.augs.org/
American Society for Gastrointestinal Endoscopy	1941	12,000	Internal Medicine	Gastroenterology	www.plasticsurgery.org/
American Society for Radiation Oncology	1958	10,000	Radiology	Radiation Oncology	www.cosmeticsurgery.org /
American Society for Reproductive Medicine	1944	8,000	Obstetrics & Gynecology		www.physiatry.org/
American Society of Addiction Medicine	1954	3,500	Psychiatry, Neurology	Addiction Medicine	www.aacap.org
American Society of Anesthesiologists	1935	44,000	Anesthesiology		www.scmr.org/
American Society of Cataract and Refractive Surgery	1974	9,000	Ophthalmology		www.asam.org/
American Society of Clinical Oncology	1964	30,000	Internal Medicine	Oncology	www.rheumatology.org/
American Society of Echocardiography	1975	11,000	Internal Medicine	Cardiology	www.aats.org/
American Society of Hematology	1958	15,705	Internal Medicine	Hematology	www.namdrc.org/

American Society of Interventional Pain Physicians	1998	3,300	Physical Med & Rehab	Pain Medicine	www.aasld.org
American Society of Nephrology	1966	12,000	Internal Medicine	Nephrology	www.snm.org/
American Society of Nuclear Cardiology	1993	4,700	Internal Medicine, Nuclear Medicine	Cardiology	www.chestnet.org/
American Society of Pediatric Nephrology	1969	600	Pediatrics	Pediatric Nephrology	www.acponline.org/
American Society of Plastic Surgeons	1931	5,000	Plastic Surgery		www.ascp.org/
American Society of Transplant Surgeons	1974	1,500	Internal Medicine	Transplant Hepatology, Cardiology	www.aapmr.org/
American Society of Transplantation	1982	3,000	Internal Medicine	Transplant Hepatology, Cardiology	www.psych.org/
American Society of Tropical Medicine and Hygiene	1903	2,700	Preventive Medicine		www.americangeriatrics.org/
American Thoracic Society	1905	15,000	Thoracic Surgery		www.aaos.org/
American Urogynecologic Society	1979	1300	Obstetrics & Gynecology	Urogynecology	www.hospitalmedicine.org/
American Urological Association	1902	17,000	Urology		www.aan.com/
Association of Academic Physiatrists	1967	1,000	Physical Med & Rehab		www.hrsonline.org/
Cardiology Advocacy Alliance	2007	5,000	Internal Medicine	Cardiology	www.acog.org/
College of American Pathologists	1946	17,000	Pathology		www.acpm.org/
Congress of Neurological Surgeons	1951	7,100	Neurology		www.aaoaf.org/
Endocrine Society	1916	14,000	Internal Medicine	Endocrinology	www.acoem.org/
Heart Rhythm Society	1979	5,100	Internal Medicine	Cardiology	www.thoracic.org/
Joint Council of Allergy & Immunology	1975	4,200	Allergy & Immunology		www.cap.org/
National Association for Medical Direction of Respiratory Care (Form 990: "Medical Directors")	1979	950	Internal Medicine	Pulmonology	www.asge.org/
National Association of Spine Specialists	1994	6,000	Orthopedic Surgery		www.osteopathic.org/
North American Society for Pediatric Gasentroentorology, Hepatology, and Nutrition	1972	1400	Pediatrics	Gastroenterology, Hepatology	www.aace.com/
Outpatient Ophthalmic Surgery Society	1981	1100	Ophthalmology		www.hematology.org/
Renal Physicians Association	1973	4000	Internal Medicine	Nephrology	www.asrm.org/
Society for Cardiovascular Angiography and Intervention	1978	4,000	Radiology	Vascular & Interventional Radiology	www.endo-society.org/
Society for Cardiovascular Magnetic Resonance	1997	1150	Internal Medicine, Radiology	Cardiology, Diagnostic Radiology	www.facs.org/

Society for Maternal-Fetal Medicine	1977	2,000	Obstetrics & Gynecology		www.sirweb.org/
Society for Vascular Surgery	1952	3,350	Surgery	Vascular Surgery	www.aap.org/
Society of Cardiovascular Computed Tomography (CT)	2005	3600	Radiology	Diagnostic Radiology	www.asco.org/
Society of Critical Care Medicine	1970	15,000	Internal Medicine, Anesthesiology, Surgery,	Critical Care	www.asnc.org/
Society of General Internal Medicine	1978	3,000	Internal Medicine		www.acsm.org/
Society of Gynecologic Oncologists	1969	1,300	Obstetrics & Gynecology	Gynecological Oncology	www.asecho.org/
Society of Hospital Medicine	1998	10,000	Hospital Medicine		www.asn-online.org/
Society of Interventional Radiology	1973	4,500	Radiology	Vascular & Interventional Radiology	www.sccm.org/
Society of Nuclear Medicine	1954	16,000	Nuclear Medicine		www.scai.org/
Society of Thoracic Surgeons	1964	6,000	Thoracic Surgery		www.aacuweb.org

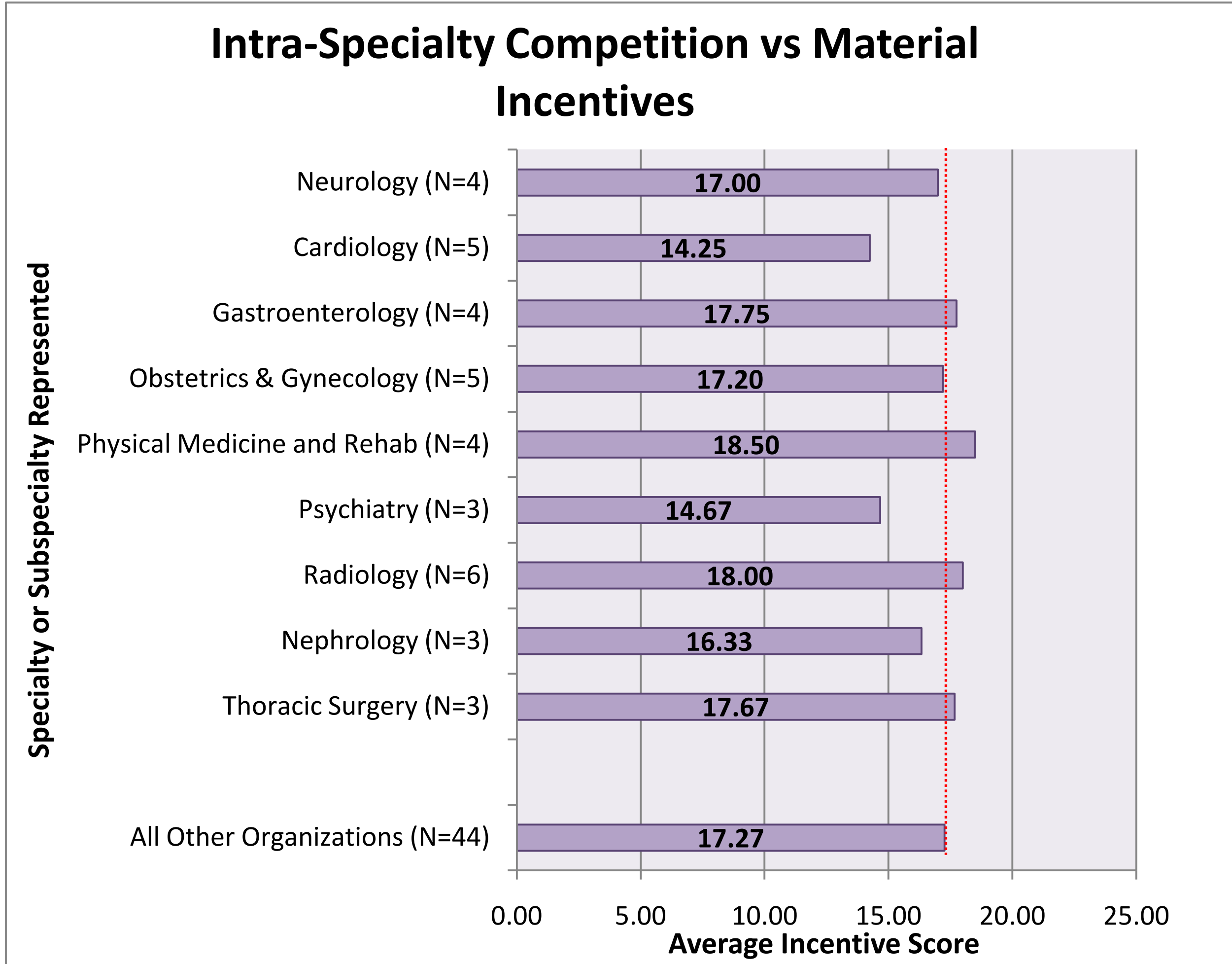
A-3: 25 Variables of Material Incentives

A list of the 25 categories which were used to determine how organizations offered material incentives.

Annual Meetings and Conference	Patient Referrals or Job Resources
Assistance on Medicare Coding and Reimbursements	Patient Education Resources/ Brochures
Access to Affiliated Centers or Organizations	Expert Clinical Advice
Courses and Education	Access to Mailing Lists or Member Directories
Resources for Maintenance of Certification or Licensure	Exclusive Grants or Awards
Discounts on Consumer Products	Clinical Practice Guidelines
Discounted Medical products	Leadership Development Programs or Opportunities
Policy, Productivity, or Work Guidebooks	Research Opportunties
Discounted Medical Liability Insurance	Practice Management Help
PR, Technology, or Media Help	Discounted Life Insurance, Car Insurance, or Other Insurance
Publishing Opportunities	Retirement / Financial Planning Assistance
Peer-Reviewed Scientific Journal	Physician Emergency Notification System
Legislative and/or Industry News Publications	

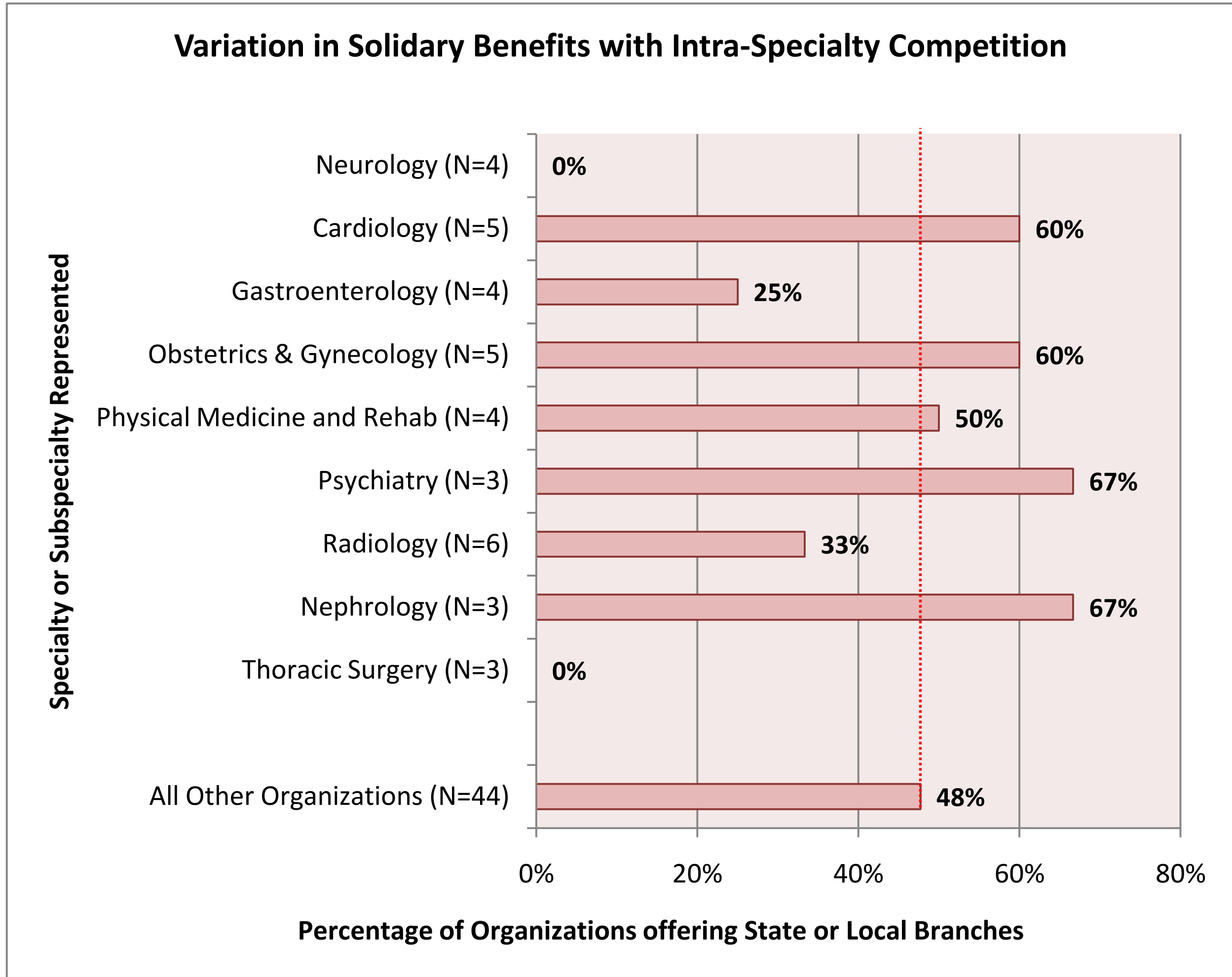
A-4: Intra-Specialty Competition and Variation in Material Incentives

As this figure shows, there is no predictable pattern as to how intra-specialty competition affects the amount of material incentives offered. This chart shows all specialties which faced a high degree of competition (≥3 groups attempting to represent the same or similar constituency).



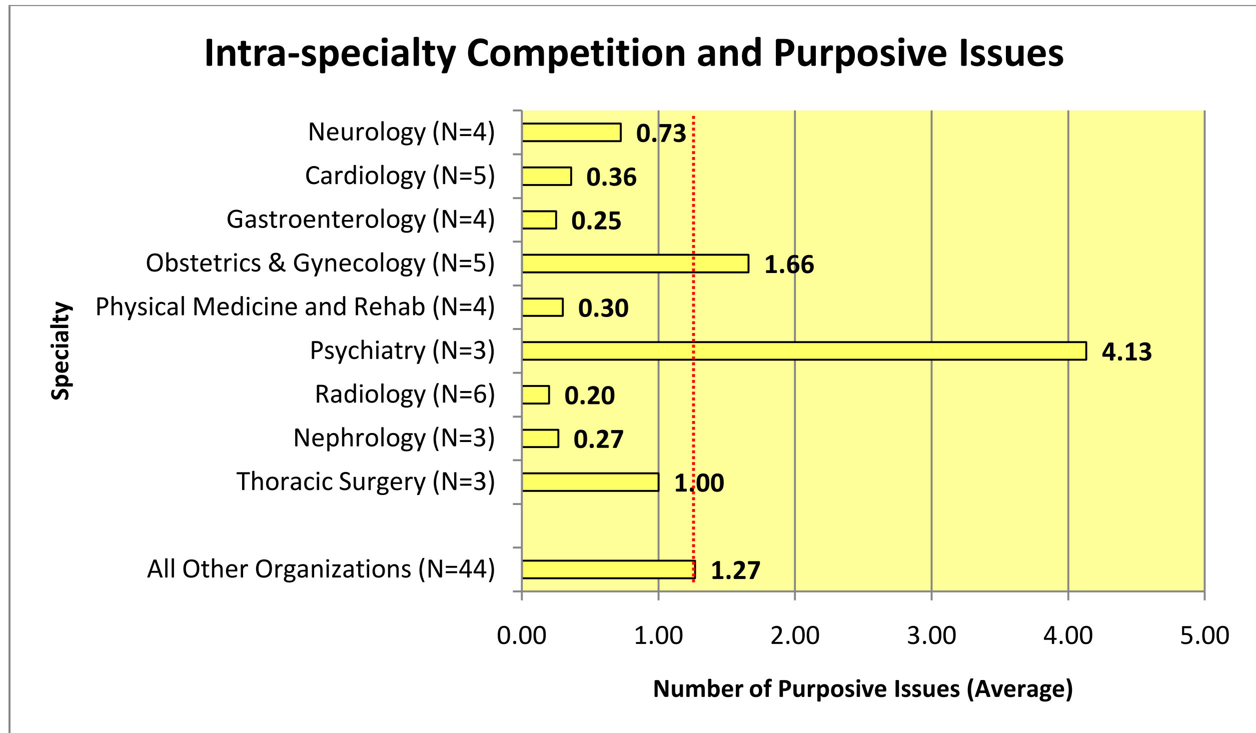
A-5: Intra-Specialty Competition and Variation in Solidary Incentives

As this figure shows, there is no predictable pattern as to how intra-specialty competition affects the amount of state and local chapters offered. This chart shows all specialties which faced a high degree of competition ($\geq$3 groups attempting to represent the same or similar constituency). Note that this graph shows the percentage of organizations within each group offering some type of formalized state or local affiliates within the fifty states.



A-5: Intra-Specialty Competition and Variation in Purposive Incentives

As this figure shows, there is no predictable pattern as to how intra-specialty competition affects the amount of purposive incentives offered. This chart shows all specialties which faced a high degree of competition (≥3 groups attempting to represent the same or similar constituency).



References

Ameringer,Carl. 2002. "Federal Antitrust Policy and Physician Discontent: Defining Moments in the Struggle for Congressional Relief." *Journal of Health Politics, Policy and Law* 27 (4) (August 2002):543-74.

Baumgartner, Frank, Jeffrey Berry, Marie Hojnacki, David Kimball, and Beth Leech. 2009. *Lobbying and policy change*. Lobbying and policy change. Chicago, IL: University of Chicago Press.

Baumgartner, Frank, and Jeffrey Talbert. 1995. "From Setting a National Agenda on Health Care to Making Decisions in Congresstes." *Journal of Health Politics, Policy and Law* 20 (2) (Summer 1995):437-45.

Belkin, Gary. 1998. "The Technocratic Wish; Making Sense and Finding Power in the." In *Healthy markets? the new competition in medicare care,* ed. Mark Peterson. Durham: Duke University Press.

Blumenthal, David, and James A. Morone. 2009. *The heart of power*. Berkeley, CA: University of California Press.

Booth, Bonnie. 2000. "Fractured Federation." *American Medical News* (October 9, 2000):14.

Burrow, James. 1977. *Organized medicine in the progressive era: The move toward monopoly*. Baltimore, MD: Johns Hopkins University Press.

Clark, Peter, and James Wilson. 1961. "Incentive Systems: A Theory of Organizations." *Administrative Science Quarterly* 6 (2) (September 1961):129-66.

Cox, Malcom, David Irby, William Sullivan, and Kenneth Ludmerer. 2006. "American Medical Education 100 Years After the Flexner Report." *New England Journal of Medicine* 355 (September 28, 2006):1339-44.

Delbanco, Thomas, Katherine Meyers, and Elliot Segal. 1979. "Paying the Physicia's Fee: Blue Shield and the Reasonable Charge." *New England Journal of Medicine* 301 (24) (December 13, 1979):1314-20.

Dorin, Adam. 2010. "How the AMA and Local Medical SocietiesFailed to Serve their Constituents." *Journal of American Physicians and Surgeons* 15 (3) (Fall 2010):85-6.

Feldstein, Paul. 1977. *Health associations and the demand for legislation: The political economy of health*. Cambridge, Massachusetts: Ballinger Publishing.

Frohlich, Norman, and Joe A. Oppenheimer. 1983. "I Get by with a Little Help from My Friends." *World Politics* 23 (1) (October 1970):104-20.

Gacreau, Oliver. 1941. *The political life of the american medical association*. Cambridge, Massachusetts: Harvard University Press.

Galvin, Tiffany. 2002. "Examining Institutional Change: Evidence from the Founding Dynamics of U.S. Health Care Interest Associations." *The Academy of Management Journal* 45 (4) (August 2002):673-96.

Garibaldi, Richard, Carol Popkave, and Wayne Bylsma. 2005. "Career Plans for Trainees in Internal Medicine Residency Programs." *Academic Medicine* 80 (5) (May 2005):507-12.

Gibbons, Robert, Frank Landry, Denise Blouch, David Jones, Frederick Williams, Catherine Lucey, and Kurt Kroenke. 1998. "A Comparison of Physicians' and Patients' Attitudes Toward Pharmaceutical Industry Gifts." *Journal of General Internal Medicine* 13 (3) (March 1998):151-4.

Ginsberg, Paul, Lauren LeRoy, and Glenn Hammons. 1990. "Medicare Physician Payment Reform." *Health Affairs* 9 (1) (February 1990):178-88.

Gold, Jenny. 2011. "Accountable Care Organizations, Explained." *NPR News* (January 18, 2011). http://www.npr.org/2011/04/01/132937232/accountable-care-organizations-explained (Accessed May 1, 2011).

Grumbach, Kevin. 2002. "The Ramifications of Specialty-Dominated Medicine." *Health Affairs* 21 (1) (January 2002):155-7.

Gutermuth, Karen. 1999. "The American Medical Political Action Committee: Which Senators Get the Money and Why?" *Journal of Health Politics, Policy and Law* 24 (2) (April 1999):357-82.

Hacker, Jacob. 2008. "Privatizing Health Politics: The Origins-- and Enduring Dilemmas-- of America's Public-Private Insurance." In *Health politics and policy,* eds. James Morone, Theodor Litman and Leonard Robins. 4th ed. Clifton Park, NY: Delmar Cengage Learning, 202-221.

Hacker, Jacob, and Theda Skocpol. 1997. "The New Politics of US Health Policy." *Journal of Health Politics, Policy and Law* 22 (2) (April 1997):315-38.

Hall, Richard, and Robert Van Houweling. 2006. "Campaign Contributions and Lobbying on the Medicare Modernization Act of 2003." *Paper Presented at the Annual Meeting of the American Political Science Association, Marriott, Loews Philadelphia, and the Pennsylvania Convention Center, Philadelphia, PA*:1-41.

Hardin, Russel. 1982. *Collective action*. Baltimore, MD: Johns Hopkins University Press.

Harris, Richard. 1966. *A sacred trust*. New York, NY: New American Library.

Hayes, Michael. 1986. "Interest Group Politics." In *Interest group politics,* eds. Allan Cigler, Burdett Loomis. 2nd ed. Washington, DC: CQ Press, 319.

Heaney, Michael. 2004. "Outside the Issue Niche: The Multidimensionality of Interest Group Identity." *American Politics Research* 32 (April 15, 2004):611-51.

Helbing,C., V. B. Latta, and R. E. Keene. 1991. "Medicare Expenditures for Physician Supplier Services, 1970-88." *Health Care Financing Review* 12 (Spring 1991):109-20.

Hiatt,Mark, and Christopher Stockton. 2003. "The Impact of the Flexner Report on the Fate of Medical Schools in North America After 1909." *Journal of American Physicians and Surgeons* 8 (2) (Summer 2003):37-40.

Hirshfield, Daniel. 1970. *The lost reform: The campaign for compulsory health insurance in the united states from 1932 to 1943*. Cambridge, Massachusetts: Harvard University Press.

Holtz-Eakin, D. 2004. *Congressional Budget Office Testimony: Statement on Medicare's Physician Fee Schedule.* Washington, DC: Congressional Budget Office.

Hula, Kevin. 1999. *Lobbying together: Interest group coalitions in legislative politics*. Washington, DC: Georgetown University Press.

Kessel, Reuben. 1958. "Price Discrimination in Medicine." *Journal of Law and Economics* 1 (October 1958):20-53.

King, David, and Jack Walker. 1992. "The Provision of Benefits by Interests Groups in the United States." *The Journal of Politics* 54 (2) (May 1992):394-426.

Landers,Steven, and Ashwini Sehgal. 2000. "How do Physicians Lobby their Members of Congress?" *Archives of Internal Medicine* 160 (21) (November 21, 2000):3248-51.

———. 2004. "Health Care Lobbying in the United States." *The American Journal of Medicine* 116 (7) (April 1, 2004):474-477.

Laugeson, Miriam. 2009. "Siren Song: Physicians, Congress, and Medicare Fees." *Journal of Health Politics, Policy and Law* 34 (2) (April 2009):157-79.

Laugeson, Miriam, and Thomas Rice. 2003. "Is the Doctor in? the Evolving Role of Organized Medicine in Health Policy." *Journal of Health Politics, Policy and Law* 28 (2-3) (April-June):289-316.

Light, David. 1991. "Professionalism as a Countervailing Power." *Journal of Health Politics, Policy and Law* 16 (3) (Fall 1991):499-506.

Lowery, David, Virginia Gray, Jennifer Wolak, Erik Godwin, and Whitt Kilburn. 2005. "Reconsidering Counter-Mobilization Hypothesis: Health Policy Lobbying in the American StatesFall." *Political Behavior* 27 (2) (June 2, 2005):99-132.

Marmor, Theodore. 1973. *Politics of medicare*. Hawthorne, NY: Aldine de Gruytor.

Marrs, Lisa, Sheila Kumar, Suzanne Perry, and Alex Richards, "Ethics and Disclosure: How Health Nonprofits Handle Contributions from Medical Companies," *The Chronicle of Philanthropy*, September 6, 2010. http://philanthropy.com/article/How-Health-Nonprofits-Handle/124276/.

Mayes, Rick, and Robert A. Berenson. 2006. *Medicare prospective payment and the shaping of U.S. health care*. Baltimore, MD: Johns Hopkins University Press.

Mechanic, David. 1991. "Sources of Countervailing Power in Medicine." *Journal of Health Politics, Policy and Law* 16 (3) (Fall 1991):485-98.

———. 2001. "The Managed Care Backlash: Perceptions and Rhetoric in Health Care Policy and the Potential for Health Care Reform." *Milbank Quarterly* 79 (1) (December 21, 2001):35-54.

Morgan, M. A., J. Dana, G. Loewestein, S. Zinberg, and J. Schulkin. 2006. "Interactions of Doctors with the Pharmaceutical Industry." *Journal of Medical Ethics* 32 (10) (October 2006):559-63.

Morone, James A. 1990. *The democratic wish*. New York, NY: Basic Books.

Morone, James A., Theodor J. Litman, and Leonard S. Robins. 2008. *Health politics and policy*. 4th ed. Clifton Park, NY: Delmar Cengage Learning.

Number, Ronald. 1978. *Almost persuaded: American physicians and compulsory health insurance, 1912-1920*. Baltimore, MD: Johns Hopkins University Press.

Olson, Mancur. 1971. *The logic of collective action*. Cambridge, Massachusetts: Harvard University Press.

Orlowski, J. P., and L. Wateska. 1992. "The Effects of Pharmaceutical Firm Enticements on Physician Prescribing Patterns. there's no such Thing as a Free Lunch." *Chest: The Official Publication of the American College of Chest Physicians* 102 (1) (July 1, 1992):270-3.

Parchman, Michael, and Steven Culler. 1999. "Preventable Hospitalizations in Primary Care Shortage Areas." *Archives of Family Medicine* 8 (6) (November 1999):487-91.

Parks, P. 1983. "Relative Value Studies: A Historical Perspective." *Bulletins American College Surgeons* 68 (11) (November 1983):2-8.

Peggy Peck, "AMA: After One-Year Increase, AMA Membership Declines again," *MedPage Today*, June 25, 2007. http://www.medpagetoday.com/MeetingCoverage/AMA/6006.

Peterson, Mark. 1993. "Political Influence in the 1990s: From Iron Triangles to Policy Networks." *Journal of Health Politics, Policy and Law* 18 (2) (Summer 1993):395-438.

———. 1995. "How Health Policy Information is used in Congress." In *Intensive care: How congress shapes health policy,* eds. Thomas Mann, Norman Ornstein. Washington, DC: Anerican Enterprise Institute and Brookings Institution.

———. 2001. "From Trust to Political Power: Interest Groups, Public Choice, and Health Care ." *Journal of Health Politics, Policy and Law* 26 (5) (October 2001):1145-64.

Poen, Monte. 1980. *Harry S. truman versus the medical lobby: The genesis of medicare*. Columbia, Missouri: University of Missouri Press.

Politzer, Robert, Dona Harris, Marilyn Gaston, and Fitzhugh Mullan. 1991. "Primary Care Physician Supply and the Medically Underserved." *Journal of American Medical Association* 266 (1) (July 3, 1991):104-9.

Quadagno, Jill. 2004. "Physician Sovereignty and the Purchasers' Revolt." *Journal of Health Politics, Policy and Law* 29 (4-5) (August-October 2004):815-34.

Rayack, Elton. 1967. "The American Medical Association and the Development of Voluntary Insurance." *Social Policy & Administration* 1 (2) (April 1967):3-25.

Rothman, David. 1993. "A Century of Failure: Health Care Reform in America." *Journal of Health Politics, Policy and Law* 18 (2) (Summer 1993):271-86.

Salisbury, Robert. 1969. "An Exchange Theory of Interest Groups." *Midwest Journal of Political Science* 13 (1) (February 1969):43-61.

Shi, Leiyu, and Barbara Starfield. 2001. "The Effect of Primary Care Physician Supply and Income Inequality on Mortality among Blacks and Whites in US Metropolitan Areas." *American Journal of Public Health* 91 (8) (August 2001):1246-50.

Shi, Leiyu, Barbara Starfield, Bruce Kennedy, and Ichiro Kawachi. 1999. "Income Inequality, Primary Care, and Health Indicators." *Journal of Family Practice* 48 (4) (April 1999):275-84.

Starr, Paul. 1982. *The social transformation of american medicine*. New York: Best Books.

Stevens, Rosemary. 1991. "Can the Government Govern? Lessons from the Formation of Veterans Administration." *Journal of Health Politics, Policy and Law* 16 (2) (Summer 1991):281-305.

———1998. *American medicine and the public interest: A history of specialization*. 2nd ed. Berkeley, CA: University of California Press.

———. 2001. "Public Roles of the Medical Profession in the United States: Beyond Theories of Decline and Fall." *Milbank Quarterly* 79 (3) (September 2001):327-53.

Stone, Deborah. 1997. "The Doctor as a Businessman: The Changing Politics of a Cultural Icon." *Journal of Health Politics, Policy and Law* 22 (2) (April 1997):533-56.

Thompson, Maynard. 1975. *Memorandum to commissioner.* Washington, DC: Federal Trade Commission, .

Truman, David. 1951. *The governmental process*. 2nd ed. Berkeley, CA: University of California Press: Institute of Governmental Studies.

Walker, Jack. 1983. "The Origins and Maintenance of Interest Groups in America." *The American Political Science Review* 77 (2) (June 1983):390-406.

———1991. *Mobilizing interest groups in america*. Ann Arbor, Michigan: University of Michigan Press.

Warner, John Harley. 1999. "American Medicine and the Public Interest: A History of Specialization." *Journal of the American Medical Association* 281 (23) (June 16, 1999):2251-2.

Waud, Douglas. 1992. "Pharmaceutical Promotions--- a Free Lunch?" *The New England Journal of Medicine* 112 (July 30, 1992):351-3.

Weissert, Carol, Jack Knott, and Blair Stieber. 1994. "Education and the Health Professions: Explaining Policy Choices among the States." *Journal of Health Politics, Policy and Law* 19 (2) (Summer 1994):361-92.

Wilkerson, John D., and David Carrel. 1999. "Money, Politics, and Medicine: The American Medical PAC's Strategy of Giving in U.S. House Races." *Journal of Health Politics, Policy and Law* 24 :335-55.