



## Los Angeles County Medical Association

In 1850, there was a brief attempt to organize some aspects of healthcare delivery in California through a society called the Medical Faculty of Los Angeles. However, not until the birth of the California Medical Association in 1856, was there a functioning organized medicine political and medical economic influence in the state of California.

“Why did mid-century physicians fail to effectively organize? They were faced with enormous problems: Quackery, encouraged by the gold rush, put more emphasis on fee schedules than on the exchange of medical information; quack hunting created animosities within the early organizations, and physician nomadism -- caused by the economic uncertainty within the cities of California -- created an unreliable membership roll.”<sup>1</sup>

Nonetheless, on January 31, 1871 some solo medical practitioners in Los Angeles solidified into a common interest group membership and began to have regular monthly meetings. Seven years later, on June 7, 1878, Articles of Incorporation were approved, seven physician members were elected to a Board of Trustees to serve as corporate officers for the first year, and the corporate name, the Los Angeles County Medical Association (LACMA) was chosen. The original seven members were Doctors: L. Orme, J. Kurtz, J. H. McKee, I. McGuire, W. Lockhart, J. P. Widney, and W. Lindley. H. L. Orme was the first president. The “object” of the corporation (as “vision, goals, and mission” were termed at that time) was to accomplish a four-fold task. Firstly, to cultivate and advance the science of medicine by united exertion, for mutual improvement, and contributions to medical literature. Secondly, to promote the character, interests, and honor of the fraternity by maintaining the union and harmony of the medical profession of the County of Los Angeles, and aiming to elevate the standard of medical education. Thirdly, to separate regular from irregular practitioners. And fourthly, to promote the association of the profession proper for purposes of mutual recognition and fellowship. The corporation’s term of existence was set at 49 years. The articles of incorporation were signed on June 24, 1878, and filed in the office of the California Secretary of State on July 3, 1878.<sup>2</sup>

LACMA hoped to prove a seemingly outlandish capitalistic business concept to be true. Compromise and sharing of individual initiative and expertise were hoped to enhance the business practices of the group as a whole as well as each individual physician in particular. The commonality also fostered development of increasingly new and profitable business innovations, and was, therefore, self-perpetuating.

For the formative years, much of LACMA meeting time was devoted to debate on defining a physician’s responsibilities to the profession of medicine in general, and more specifically to the individual patient and to the community of patients. There were no standing committees, only a Board of Trustees. LACMA physicians collaborated and voted to establish a uniform fee schedule. Transparency and fairness ruled, and no one accused the doctors of “price fixing”. Quacks, charlatans, shamans, and pretenders were recognized as threats to the general public welfare, and LACMA ferreted them out of their practices. Medical practices in the community that were deemed to be sub-standard were placed on a blacklist, and LACMA physician members were advised to avoid consulting with those sub-standard practices on the blacklist. General county public sanitation practices and purification of water in the Los Angeles basin were major health-safety concerns, and LACMA took corrective action to improve the general health of Los Angeles County residents. LACMA created a city board of health and a position of city health officer to oversee the public welfare.

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<sup>1</sup> Gray, Barbara B., 120 Years of Medicine, Pioneer Publications, Inc., 1991. p. 21.

<sup>2</sup> Los Angeles County Record, book 27, p. 60.

During the incipient years of the 20th Century, LACMA directed an increasing amount of attention to the continuing education of new and practicing physicians.

Before 1910, there was no uniform standard for educating a Physician. Curriculum content and teaching practices in what were termed “medical schools” varied from esoteric to incompetent. All sorts of educational and apprenticeship organizations produced a motley spectrum of “doctors”, from ritualistic voodoo type healers to professorial pontificators. Marginal, yet profitable, physician-run proprietary training programs, some by mail order, enlisted any and all who desired entrance into the medical profession. Demographically poor and ethnic-cultural needs were serviced primarily by proprietary-trained practitioners. At the very top of the diverse practitioner heap stood homeopathic, osteopathic, and allopathic physicians. The idea of having some scientific method to determine treatment remedies was novel for the time, but encouraged by all three types of physicians.

A College of Medicine existed at the University of Southern California since 1885, and with help from LACMA, a College of Physicians and Surgeons was established in 1903. LACMA, in conjunction with the AMA, was instrumental in developing and setting standards for medical education and in approving standards for medical schools. The College of Medicine was transferred to the regents of the University of California in 1909, and it became known as the Los Angeles Medical Department of the University of California. After 1910, the climate for educational and practice standards in medicine changed. Doctor Abraham Flexner began an investigation study in 1906 that was finished in 1910. The watershed document was entitled, “Medical Education in the United States and Canada, A Report to the Carnegie Foundation for the Advancement of Teaching”. The school at UCLA closed as a result of the report, and the College of Physicians and Surgeons eventually closed in 1919 due to financial problems.

The nascence of organized healthcare delivery within the LACMA organization began in 1913. Doctor Ray Lyman Wilbur proposed a voluntary type of prepayment insurance plan that would be under the auspices of LACMA.<sup>3</sup> That prepay healthcare delivery strategy proved to be a very unpopular concept for the LACMA members, but interest in the concept did gain support, albeit at an extremely slow and painful rate. Not until twenty-five years later, on December 17-18, 1938, did the council of the California Medical Association (CMA) grant approval.

LACMA membership continued to grow as the population of Los Angeles also grew, and both sprawled geographically. A better understanding for grass-root medical problems from local areas was necessary. Local LACMA districts were drawn up according to local needs. Each local district, or “branch” developed a board of governors, separate from but responsible to the governors of the central LACMA board of trustees. By 1918, the branches consisted of Pasadena, Pomona, Long Beach, and Santa Monica. LACMA refunded a portion of the central dues to the branches to enable the branches to carry out local branch business. In 1919, the central dues (\$17.50) were lowered to a flat rate of \$10.00, and the branches each set up their own separate and additional dues structures. A political action group, not the Los Angeles County Political Action Committee (LACPAC), but the “League for the Conservation of Public Health” was formed to combat influences from anti-vivisectionists, Chiropractic Initiatives, and the Osteopathic Referendum. The League was formed to separate LACMA business interests from LACMA political interests, and there was no Council seat for the League chairman. Likewise, when LACMA formed LACPAC, the same strategy followed. The traditional interest policy of LACMA was to have no direct controlling linkage to political action groups.

Smog in the Los Angeles basin, became a major health concern for LACMA in the 1950’s. LACMA led the successful fight to lobby for automobile emission standards. The fact that cigarette smoke kills people was introduced to the public welfare through 35 separate resolutions spanning over 40 years (1950-1990), by a LACMA member, Dr. Albert Fields. He and LACMA also championed the concept of second-hand smoke as a health hazard. His continued tenacity against the advertising and marketing of cigarettes resulted in the removal of cigarette vending machines from educational and health facilities as well as the

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<sup>3</sup> LACMA, A struggle for Excellence, Anderson, Ritchie, and Simon, 1971, p.52

cessation of smoking in public places throughout the state of California, and eventually throughout the remainder of the United States.

Medical tort reform came to a crisis in 1974. Doctors throughout California were about to strike and many were leaving the state to practice elsewhere. LACMA president William Plestead led the successful fight for MICRA legislation all the way to Sacramento.

Along with the advent of local branches or districts, LACMA established a Board of Councilors. As the size of the organization increased, a new management structure became necessary. The LACMA Council remained separate from the seven-member Board of Trustees. The officers of the corporation were chosen from the Trustees. The Councilors chose the Trustees. Each Councilor was elected as a representative from one of the various local LACMA branches (districts) and/or LACMA specialty practice interests. Each branch elected its own governance. The duties of the Trustees were to see to the financial stability of the LACMA Corporation. The duties of the Councilors were to act on the practical day to day events that altered the climate of medical practice. Control of LACMA funds became a joint venture. The Council had its own set of officers, separate from the Trustee corporate officers. With the Trustees ensuring the financial stability of the organization, Councilors could more effectively act upon the day to day affairs affecting the lives of LACMA physician members -- on such matters as opposition to state controlled health insurance programs and to closed panel prepay healthcare delivery organizations.

Organized medicine organizations (LACMA, CMA, and AMA) were initially all inter-linked in a common dues structure. Membership in LACMA required simultaneous membership in CMA and AMA. Up until 1960, the LACMA Council elected delegates for the annual CMA convention. The CMA delegates, in turn, elected delegates to attend the annual AMA meeting. After 1960, the general LACMA membership elected both CMA and AMA delegates. In the third medical economic generation (1990-2010) LACMA membership no longer required AMA membership. AMA delegates were for a time elected by the local AMA membership, then the process changed and AMA delegates again became elected by the LACMA delegation to the CMA.

In 1936, the LACMA restructured by-laws to conform to California Medical Association (CMA) requirements. The LACMA Council no longer appointed LACMA Trustees; Trustees became elected directly by and from the total LACMA membership. In 1941, United States citizenship became required for full membership, and the LACMA trustee president also became the president of the LACMA Council.

LACMA's final attempt to censure closed panel medical practice as "unethical" ended in 1953, when a resolution passed on to the CMA was refused placement on the agenda for the subsequent AMA meeting. Eventually large group practices became recognized as non-geographic districts and elected councilors to the LACMA board of directors.

In the year 2000, the council and trustees combined into a single LACMA board. The number of trustees had grown to ten, and the trustees were renamed "councilors at large." The entire LACMA membership elected the corporate officers. Geographical districts, non-geographical districts, and mode of practice organizations elected the councilors. Continuance of the ten "councilor at large" positions was deemed necessary to provide sage guidance from former corporate officers and other doctors with specific expertise or proven potential for future leadership as well as to offer a starting point for physicians interested in becoming corporate officers.

Opposition to compulsory health insurance continued well into the second medical economic generation of organized healthcare delivery (1970-1990). In 1971, the LACMA centennial anniversary book reaffirmed the opinion that the doctor-patient relationship was "being threatened by the spectre of compulsory health insurance".<sup>4</sup>

By 1931, it became obviously apparent that medical economic changes had restructured the California patient population's ability to pay for healthcare delivery. Lucrative risk payer pool demographics had

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<sup>4</sup> LACMA, [A Struggle for Excellence](#), p. 15.

changed. LACMA could no longer ignore the potential benefits and absolute necessity for some healthcare delivery in a prepay form. A paradigm shift in the LACMA philosophy towards organized healthcare delivery was essential. A prepay contract was negotiated with the Los Angeles Metropolitan Water District (MWD). The contract upheld and preserved the autonomy of private medical practice. The LACMA contract differed from the Ross-Loos agreement in that each employee of the MWD could freely choose a fee-for-service LACMA physician. Although established before either existed, the contracting arrangement was more of a PPO rather than a PSO.<sup>5</sup>

There was an ongoing philosophical split among the councilors regarding pre payment and insurance supported medical care. In April of 1932, LACMA's Council agreed to "purify the Association, study (with a study of) the conduct of practice of various groups now carrying medical service (organized healthcare delivery) on a monthly fee basis and employing medical talent (MDs) on a salary basis. In the event members of the Association are deemed guilty of unethical practice, expel them from membership in the Association. In other words, after careful deliberation, a decision should be made as to whether certain practices now conform to the Code of Ethics or not, and that we no longer temporize, but arrive at a standard and adhere to it."<sup>6</sup> (Doctors Ross and Loos were expelled from LACMA in 1934. They were reinstated in 1935 by vote of a new LACMA council.)

Meanwhile and quite to the contrary, LACMA was developing its own Medical Service Plan with provisions for free choice among fee-for-service physicians. A non-profit corporation, set up and controlled by the doctors, provided healthcare delivery for workers. All LACMA physicians were able to participate. There was no lay influence, no union influence, and no governmental influence in the healthcare delivery organization. The LACMA membership approved the plan in October of 1933. The need for hospital insurance was also recognized, and the topic was hotly debated until November of 1938, when, after recommendation by the AMA, a combined prepay plan, the California Physicians Service Plan of the California Medical Association, was finally approved by LACMA. It was basically a PPO.

One month later, the Council of the California Medical Association approved the prepay plan, officially named "California Physician Services". The name, however, was soon changed and the plan was more commonly known to provide organized healthcare delivery services in California as Blue Shield of the CMA. Both hospital and physician services were, for a time, covered. The individual patient was responsible for a 20% co-pay for each service rendered. In order to simplify bookkeeping and billing, and to satisfy internal philosophical differences, Blue Shield was eventually split from the CMA and became an independent non-profit organization. The small hospital service plan remnant was absorbed by an existing Blue Cross, and was sold as a companion policy. In the third medical economic generation (1990-2010), Blue Cross became America's largest for-profit Health Keeper Organizations (HKO).

Blue Cross and Blue Shield insurance policies sold at an exponential rate. Organized healthcare delivery in the form of indemnity insurance was set to dominate the healthcare marketplace, not only in California, but also across the then 48 states during the first overlapping medical economic generation of changing healthcare delivery (1950-1970).

LACMA non-dues revenue rose to exceed 60% of total revenue. In order to maintain its non-profit status (a corporation that benefits the public) and reduce its tax burden, LACMA created a for-profit subsidiary corporation in 1984 and named it LACMA Services Incorporated (LSI). LACMA reduced conflict of interest fears by directing all non-dues revenues through LSI. LSI then functioned as a "common paymaster". LACMA owned 79% of LSI and the LACMA Foundation for Community Services owned 21%. LSI paid for all LACMA employees and LACMA administrative services. Volunteerism, private enterprise, individual responsibility, and work ethic continued as prime LACMA values.

LACMA had previously aligned itself with a non-profit Foundation for Medical Care in 1983 (LAFMC). The unstable IPA component of LAFMC was sold to Cigna Healthcare in 1985, just in the nick of time, or

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<sup>5</sup> Preferred Provider Org., Physician Sponsored Org., see Equalization Era (1990-2010) chapter, Medical Ecolonomics, 2001.

<sup>6</sup> LACMA, A Struggle for Excellence, p. 53.

in LACMA terminology, a right-effect / right-time “precision engagement”. The PPO component remained viable while paying rates equivalent to 120% of Medicare. An EPO (Exclusive Provider Organization) component, which discounted the PPO, never became very popular. In contrast, the workers’ compensation component, which discounted the state rate by 10%, continued to be quite lucrative. In 2007, LACMA voted to dissolve the LAFMC.

The political orientation of LACMA continued to evolve during that third overlapping generation of organized healthcare delivery. LACMA had chosen to aid membership enrollment by making the organization all-inclusive -- LACMA had given representation to all formats of medical practice. The percentage of LACMA members from solo and small group practices continued to shrink as the managed care community grew. The percentage of membership from large group practices increased, partly due to group-health plan administrations subsidizing the LACMA dues. Large HKO groups joined LACMA as “non-geographic districts”, and paid LACMA with a single check for multiple discounted memberships. Individual membership recruiters promised solo and small group physicians’ collegiality, protective lobbying (advocacy), and networking. The overall membership roles shrank precipitously. A private practice perception of disenfranchisement, that had been a problem with AMA membership, extended to include LACMA. Philosophical and business-oriented decision making between private practice and HKO groups did not reach consensus in the new, all-inclusive LACMA organization. When LACMA backed CMA bill AB1600 to end de facto HMO exemption from Knox-Keene legislation, the HKO enterprise liability skeleton let itself out of the closet. AB 1600 was the key that unlocked the door to strong dissension among the newly combined LACMA membership.

New dynamic competitive strategies became urgently necessary. In 2006, LACMA successfully lobbied against a California ballot proposition that would have extended anti-trust exemptions to hospitals. With united activism, LACMA helped rescind a governor’s order to end the ability of physicians to bill for the unpaid balance of their usual, customary, and reasonable fee when dealing with a non-contracted insurance agency (balance billing). In 2007, LACMA lobbied for the re-establishment of Drew Medical School and the building of a health safety net for the residents in the south Los Angeles corridor. LACMA developed a task force for healthcare delivery reform; and with consensus from all modes of physician practice, developed a common set of pre-requisites and principles. This landmark reform package was delivered to the CMA and the California legislature. Membership, political interest, and respect for the LACMA organization substantially increased in 2006 and continued into 2007. A new order of organized medicine regained unity and assured future success for LACMA into the 21<sup>st</sup> Century.