On the one hand, existing groups would oppose letting commercial publishers revise the books independently and probably would be equally reluctant to turn the job over to another group. And on the other hand, NSF is determined above all to avoid being a party to the creation of anything that amounts to a national textbook.

As a matter of general policy, therefore, the Foundation in the future can be expected to put more emphasis on allotting funds for course content improvement to programs that stress innovation and experimentation rather than implementation in the schools.

The agency, however, faces immediate problems like those involving BSCS. Foundation staff members say that if the return of BSCS to AIBS tutelage proves not to be a workable solution, NSF is willing to consider other arrangements. But, as one official put it, "Negotiations are going slowly." In the case of BSCS, too long a delay in making a decision may be decisive.

—JOHN WALSH

AMA (II): Doctors' Organization Faces Growing Outside Criticism, Wide Range of Policy Problems

The temporary rout, if not defeat, of the "boycott medicare" party at the convention of the American Medical Association in New York last month produced a flurry of assertions in medical circles and in the press that the AMA had reached a "turning point." Whether the association will now take a more positive role in guiding the changes in medicine that medicare and other developments will be bringing about is far from clear. At the moment, most of the omens are negative. But a significant feature of the commentary on the AMA's action is an apparently widespread feeling that the AMA has reached a point at which some kind of "turning" is essential.

The editorial writers and others who feel that the stand taken at the AMA convention presages an era of moderation and cooperation rest their case on two principal points—first, the absence of a declaration of war on medicare, and, second, a rather guarded offer to cooperate with the government in writing the rules and regulations under which the medicare program will be administered. These concessions on the part of the AMA are surely to be welcomed—but there is a good chance that their significance will be limited. In the first place, it is not certain that the AMA leadership would be able to contain a strike by large numbers of individual doctors. Boycott sentiment is particularly strong within the states that introduced boycott resolutions—Arizona, Ohio, Florida, Texas, South Carolina, Louisiana, Connecticut, and Nebraska—and is reported to be heavy also in New Jersey and Kansas. (In general, support for a boycott is believed to be strongest among small-town physicians, with doctors from big cities more disposed to go along quietly, if not happily, with the program.) How long such individual boycotts might continue, or what their consequences might be, no one can say. Many outside observers predict that a strike would fail when doctors discovered that, far from interfering with either their practices or their pocketbooks, medicare would actually improve both. This theory rests on the proposition that, since doctor's incomes are basically dependent on the amount of medical services they provide, any system which tends to encourage more patients to seek needed medical care is good for the doctors as well as for the patients—particularly where reimbursement is guaranteed. Nonetheless, it might easily be some time before such rational economic benefits were perceived, and in the interim a strike—even if not officially endorsed—could impinge on the "moderation" of official policy. The usefulness of the AMA's offer to negotiate with the government on medicare is also open to question, not because it is insincere but because it is accompanied by the old policy of continuing to attack and resist medicare as much as possible. If the AMA has "turned," it is by no means now facing in the opposite direction.

The Next Battle

Outside of these last-ditch changes of attitude toward medicare, the AMA has given few signs that it is about to abandon the style or the precepts which have led to the waning of its influence in both political and medical-scientific circles. First on the AMA's post-medicare priority list is the administration's proposal for federally supported regional centers for research and treatment in heart disease, cancer, and stroke—which it intends to oppose as forcefully as possible. The AMA's suspicions of the proposed centers first became known when Hugh Hussey, AMA director of scientific activities, resigned from the presidential commission working on the proposal, reportedly on the grounds that he foresaw a conflict with AMA policy. When the report was completed, the AMA published a staff report in its journal charging, among other things, that the recommendations rested on unproved assertions about the inability of American physicians to keep up with advances in medical knowledge. At the convention the delegates resolved to oppose "those particular Commission recommendations which call for and have stimulated proposals for hastily contrived and unproven sweeping changes in the pattern of medical research, education, and patient care." This resolution was adopted after considerable debate in which the original wording, which endorsed the intent of the president's commission while opposing its methods, was replaced by wording which omitted praise for anything but "existing patterns of research and medical practice." Later, AMA officials privately confirmed their intent to make the regional centers "the next major medico-political battle." (A bill supporting the regional centers was passed by the Senate on 28 June and sent to the House Interstate and Foreign Commerce Committee, where hearings are scheduled to begin 20 July.)

The AMA is by no means alone in its opposition to the new federal program. It is true that in the Senate hearings the bill was supported by the American Heart Association, the American Cancer Society, the Association of American Medical Colleges, the American Hospital Association, the American Dental Association, and the American Public Health Association, as well as by the influential members of the DeBakey Commission, who invented the scheme. Outside of these groups, however, there appear to be growing numbers of independent physicians and usually sympathetic politicians who are publicly skeptical about some of the bill's assumptions and implications. Even among its early supporters there is a growing tendency to temper the initial rejoicing with caution. But while it is evident that opposition to the bill is becoming respectable, it is unlikely that the AMA's particular objections will find an attentive audience.

Medical politics is something like the children's game in which you can advance only if you remember to say "May I?" Its political equivalent consists of seeming to support proposals even while suggesting changes that would alter or undermine them. The

key to influence lies in genteel formulations of points of difference—and it is just this gentility which the AMA's blunt denunciations already appear to lack. It thus appears to many observers that the AMA is likely to find itself as isolated in the coming battle over the regional centers as it was over medicare, and that a situation is shaping up in which a second major health program will be developed without the advice or concurrence of the doctors whom it principally affects.

Discrimination Issue

Another issue affecting the reputation of the AMA is the question of racial discrimination. The AMA has a federal structure, with membership requirements determined locally. Exclusion of Negro physicians from membership in state and local medical societies —a situation common in the South— automatically excludes them from eligibility for the national organization. But while the AMA leadership is cognizant of the problem—and recognizes that comparatively few Negro physicians are represented in the AMA—it contends that the national organization lacks the power to interfere with policies established by its constituent units.

The discrimination issue has been simmering for some time—it was evident in 1963 when a handful of physicians picketed the AMA's annual meeting in Atlantic City, calling for an end to discrimination—but it was given new strength this year by the formation of a new organization of doctors known as the Medical Committee for Human Rights (MCHR). The MCHR was organized chiefly to funnel medical assistance to civil rights activists working in the South—a sizable contingent was present in Alabama during the Selma-to-Montgomery march last winter. But it has other objectives, among them the reform of the AMA, and it organized a demonstration of more than 200 Negro and white physicians outside the New York Coliseum where the AMA's scientific meetings were being held, urging the association to revoke the charters of local medical societies that discriminate against qualified Negro doctors. (AMA leaders, deeply involved themselves in discussions of a medicare strike, added a gloriously ironic note when they issued a statement denouncing the MCHR for espousing tactics of "intimidation, pressure [and] picketing.")

While the MCHR's proposal was never brought before the house, the delegates did consider a resolution by the New York state delegation that the AMA establish a category of direct AMA membership to accommodate qualified physicians denied admission to their local societies. That proposal was vetoed. Instead, the delegates voted to reaffirm the AMA's previous position, which consists of formal opposition to discrimination, unaccompanied by any sanctions or threat of sanctions.

But though the convention maneuverings would seem to have left the discrimination issue in dead center, in fact the situation is far from stabilized. One potential force for change is a bill introduced by Representative Joseph Resnick (D–N.Y.) calling for the lifting of the tax exemptions of nonprofit organizations which discriminate. Resnick is a first-term Congressman with limited influence, and the House Ways and Means Committee, to which the bill was referred, shows no interest in the subject. But in this period of determined attention to all manner of civil rights proposals it would not be surprising if Resnick's scheme found echoes elsewhere; if it does, it would not be surprising if AMA lawyers suddenly found loopholes in the constitutional restraints which they now claim make national action impossible.

A second factor which could alter the AMA's stand on discrimination is the MCHR itself. So far the MCHR is small and its active adherents are scattered. But a number of influential physicians and scientists—Alan Guttmacher, Louis Lasagna, Paul Dudley White, Albert Sabin, Howard Rusk, Irving S. Wright, Albert Szent-Gyorgyi, Benjamin Spock, and many others—have lent their names to its activities. And it is the feeling of several of the physicians involved with the committee that it could conceivably become the organization to lead the attack on the AMA, not just for discrimination, but for what many MCHR adherents regard as its retrograde policies on other social and economic questions.

Competition

The AMA's loss of influence is by no means exclusively related to its strategy of total resistance to medicare. In part it reflects also the rise to national influence of other groups with some claim to represent "medicine" to the public. One contender for this role is the Association of American Medical Colleges, which has recently set up headquarters in Washington with the intention of maintaining closer ties with government agencies and with Congress (*Science*, 25 June, p. 1700). Another is the American Hospital Association, whose growing influence reflects both the increase in "hospital-based" medicine and some sensitive and enterprising work in the field of congressional relations. Still a third is the informal alliance of medical specialists and researchers defined in part by their association with Mary Lasker and known in shorthand as the "Laskerites." These individuals—among them physicians such as Sidney Farber, Michael DeBakey, and Howard Rusk—have been key figures in the expansion of federal support for medical research. When Congress needed advice on matters connected with medical research, or an executive agency needed consultants, they have been apt to draw on this circle of specialists rather than on the AMA. (The roster of the Heart, Cancer and Stroke Commission is a good example.)

These individuals seem to have been not so much hostile to the AMA as indifferent toward it. Elsewhere in medical circles, however, criticism of the AMA has been growing. In large part, the criticism has been directed to the style of the AMA's attack on medicare. The *New England Journal of Medicine* said recently, for example, that "the techniques used in opposing medicare seem to have been based too much on an unwillingness to face facts and too little on reason and diplomacy." This attitude, the *Journal* continued, "has tended to reinforce the public belief, however groundless, that the profession as a whole is insufficiently concerned with the needs of the less privileged members of society." Further criticism

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A Controversy Ends

A bill providing medical care for the aged under Social Security was passed by the Senate last Friday by a vote of 68 to 21. Differences between the Senate measure and a version passed by the House in April will be taken up by a conference committee shortly. It is anticipated that a final bill will be ready for the President's signature in about 2 weeks. A major portion of the benefits will become available in July 1966; the remainder, in January 1967.

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was recently found in the pages of *Medical World News,* an influential trade weekly edited by a former editor of the *Journal of the American Medical Association,* Morris Fishbein. And another critic, John Freymann of Worcester, Massachusetts, also writing in the *New England Journal of Medicine,* pointed out that an important consequence of the AMA's loss of influence is that measures affecting doctors no longer originate "from planning by the medical profession." "No longer a positive force," Freymann said, "the AMA, and with it the entire medical profession has . . . been in the negative position of supporting or opposing programs conceived by the laity and carried forward on the fitful winds of public demand."

Other critics have felt that the medicare campaign (and, they fear, the coming battle) have been degrading in a more immediate sense—that in order to collect the funds needed to support its political campaigns the AMA has compromised the formerly high standards governing the advertising of drugs in its journals. Rumblings that even the scientific sessions of the AMA were not attracting the first-rate exhibits and programs that they once had were heard frequently in New York. For those who feel that the AMA has already "gone political" in an irretrievably damaging way, the reportedly close voting for president-elect during the convention provided no comfort. In the end the delegates elected an AMA regular, Charles Hudson, of Cleveland, a professor at Western Reserve and at the Cleveland Clinic. But among Hudson's competitors were two politicians—former Representative Walter Judd (R–Minn.), a defeated congressman, and Representative Durward Hall (R–Mo.), a third-term congressman with relatively little influence. Both these men are physicians (Hall is a member of the AMA House of Delegates), but the sentiment for them was largely based on the notion that "we need someone to look after us in Washington." Election of either one would have jeopardized the AMA's claims to be taken seriously as a professional organization; that the contest required three ballots is some indication of how the AMA these days is viewing itself.

Which came first, the rise of alternative centers of power in medicine or the erosion of the influence of the AMA, is difficult to say. Earlier in the association's history—chiefly in the period before World War I—the AMA was crucial in the reform and standardization of medical education, and was even found advocating such progressive schemes as social insurance. In that period, it seems to have been dominated largely by academic specialists. Later, the academicians seem to have withdrawn from leadership, leaving the AMA to become, increasingly, an organization of practicing physicians whose ties to academic medicine were limited to their own years in medical school. It has been the practicing doctors, almost exclusively, who have worked themselves through local and state medical societies to positions of influence in the AMA.

The relative indifference of academic physicians to local medical affairs—hence their lack of power in the AMA—is reflected in the composition of the most recent House of Delegates. Of 233 delegates, the general practitioners (51) were the largest single group, followed by general surgeons (42), internists (35), and obstetricians and gynecologists (25). After these groups, which constituted over half the delegates, the next largest groups were in administrative medicine and urology, with 8 members each. Beyond that, other specialties were hardly represented; a few were literally not represented at all.

The difficulty with this highly skewed array is not so much that it fails to reflect the manpower levels of various specialties (GP's, after all, still represent the largest number of U.S. physicians; and the only two groups conspicuously underrepresented are psychiatrists and pediatricians) but that the domination of GP's occurs at a time when it no longer reflects trends affecting medicine as a whole. The AMA delegates, who set the organization's basic tone, appear to be trailing behind in two important ways. First, many people believe that the entrepreneurial tradition of independent practice which characterizes the AMA delegates is isolating them from the mainstream of actual medical practice, which is increasingly scientific rather than personal, corporate or group rather than solo, and increasingly based around medical schools and hospitals. Second, the delegates, as the annals of the convention indicate, are if anything even farther removed than their leaders from currents affecting the social and political climate in which medicine will be practiced: they are more opposed to medicare, less disposed to interfere with existing patterns of segregation, more opposed to federally constructed heart and cancer stations, and so forth. As for what is to be done with the AMA, no one seems to have any ideas. Internal reform is made improbable by the very localistic structure that has produced many of the AMA's problems—those who would have to be reformed are the same people who would have to do the reforming—and by the aggressive, sometimes almost frenzied, self-satisfaction that has been the AMA's trademark. Reform from the outside is unlikely because those who might take on the job have been apathetic, and the groups that have risen seem willing or ready to challenge the AMA on only a narrow fraction of the issues with which doctors must deal. At this point, the chances that the AMA will be modernized appear slim. But it is safe to say that if the AMA does not change some of its ways, we will all be the worse for it—the doctors, because they will find themselves the servants of programs they neither like nor understand, the public because, for better or worse, these are the only doctors we have.—ELINOR LANGER

Announcements

A **laser research** program, sponsored by a grant from the Boeing Company, has been established at Tulane University's department of electrical engineering. Research will be conducted in a special laser laboratory equipped with lasers from Boeing and with Tulane microwave equipment. The project aims to evaluate the use of lasers to provide on-the-pad communication with rockets and to penetrate the ionized sheath of gases created during rocket lift-offs. The program will be coordinated by Walter Nunn, professor of electrical engineering at Tulane, and Curtis Toliver and Joseph Lopez, engineering supervisors in Boeing's communications technology unit.

The **Yerkes Regional Primate Center** this month was moved from Orange Park, Florida, to the campus of Emory University. The collection of primates will be housed at the center's new quarters on the Atlanta campus and at the 117-acre field station near Lawrenceville, Georgia, about 25 miles from Atlanta. The center was established in Florida by Yale University in 1930, and given to Emory in 1956.