Public Roles for the Medical Profession in the United States: Beyond Theories of Decline and Fall

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WHAT IS THE FUTURE OF MEDICINE IN THE PUBLIC sphere, as expressed through its professional organizations? Will the profession continue to be just one of many competing interest groups, whose influence will continue to wane? Or is there a basis on which the professional organizations of medicine might assume a new position of moral leadership in American health care? This latter question is seldom asked, perhaps because the answer seems preordained by our understanding of the recent past and projection of that past into the future. Notwithstanding its direct stake in many health policy questions and its perennial ranking near the top of political contributors, organized medicine has become conspicuous politically by its marginality among a cacophony of players, demoted from center stage and seen as just another self-interested player.

Moreover, strong competition has developed over the issue of quality, a topic long monopolized by medical organizations through their control of education, training, and credentialing of physicians. Quality is now seen as a legitimate concern for purchasers, managed care plans, provider organizations, politicians, and consumers and is the subject of serious measurement and reporting efforts under a variety of auspices. Quality improvement of patient care requires effective management of complex

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systems (Kohn, Corrigan, and Donaldson 2000; Committee on Quality of Health Care in America 2001).

Structurally, too, organized medicine has fragmented. These days, physicians see their specialty societies as their primary professional representatives, and the medical profession has splintered into hundreds of diverse organizations. The American Medical Association (AMA) represents a minority of all physicians. A recent article in the AMA's *American Medical News* put the question succinctly: "Is it time for the end of organized medicine as we know it?" (Booth 2000).

For those who see medicine's public role only in terms of its efforts to enhance the well-being of its members, such a prospect would not be regretted (or perhaps dismissed as inconsequential). However, this is hardly the most intellectually creative or socially helpful stance one can take when considering what medicine's national voice and organizational roles in American health care might be in the future. Is there potential for the professional organizations of medicine to serve a positive role? This paper sets out to examine this largely neglected question by considering alternative explanations for that role in the past, assumptions in the present, and possibilities for the future.

Other scholars are redefining the multifaceted meanings of "professionalism" (Freidson 1994; Wynia, Latham, Kao, et al. 1999; Rothman 2000; Mechanic 2000). While professionalism is being widely discussed today in medical meetings, in medical schools, and as part of bioethics programs throughout the United States, it is only beginning to be developed as a rationale and strategy for the profession's collective, organizational, public roles. Beyond new definitions, there is an incipient movement toward finding new concepts and language through which change might take place. These tasks represent a challenging undertaking for scholars and other commentators on medicine in the United States compared with other countries. Historical narratives dominated by the story of organized medicine's rise and fall, suggesting a defeated profession, have sustained its weakened political status. Nevertheless, an alternative history, which stresses the value of organized medicine's public activities, could be recounted in a way that allows the profession to play a role that does in fact further public interest.

Plausible arguments can be made for strengthening the profession's public roles. Attacks on the imagined role of medicine as an entity, as well as major changes in purchasing arrangements and the power of payers since the 1990s, have caused demoralization, confusion, and cynicism

among people in the profession, which affect, in turn, those people who wish to negotiate with it. Physicians now feel marginalized and under siege, not only because of the constrictions and regulations of health insurance contracts but also by their symbolic understanding of where the profession stands today. Historical theories of a profession in decline have lost their utility for explaining the present; that is, as grounded policy assumptions on which to build high-quality health services for the next 20 or so years. Most obviously, current understandings within the profession suggest limited possibilities for physician involvement in improving the public's health—at a time when population health is an important issue—and a shift to defensive tactics. These latter include the AMA's abortive efforts in the 1990s to sell its name as a trade endorsement to the Sunbeam Corporation, and the ongoing organization of physician bargaining units designed to exert countervailing power against insurers.

In theory, at least, a revived, socially confident medical profession, exerting moral leadership at the national level, might help create reform coalitions and build practical consensus among otherwise competing groups. Despite recent negative critiques, the American medical profession actually has a long history of public service, though that history has been submerged in recent years. In short, the profession's public roles are overdue for updating to meet today's scientific, economic, and political conditions, and there is an alternative (or secondary) history of the profession on which to build.

Basic Questions

Policy groups and medical leaders throughout the world are tackling the restructuring of professional roles, responsibilities, and organizations in the first decade of the 21st century. In most countries, the role and authority of the medical profession have been strongly influenced by the extension of national government health policy over the past 50 years. For example, in the Canadian provinces, which have a single-payer insurance system under government auspices, medical organizations carry substantial delegated authority. In Europe, medical organizations may constantly find themselves renegotiating and contesting for power with government, but they at least have a national role to renegotiate and contest (Freeman 2000; Moran 1999). In the United States, there has been no similar concentration of responsibility for universal health insurance at

national, state, or local levels, and no single government agency responsible for delegating formal power to medical organizations in relation to organized payment and service systems.

The growth of managed care in the 1990s, though in some ways as revolutionary in its effects on doctors as universal governmental health insurance might have been, was a dispersed rather than national experience, with substantial variations from place to place. With the typical physician having contracts with multiple insurers rather than with a single payer, the financial power of insurance corporations is disseminated—and so, therefore, is the negotiating power of physicians. Thus, even at the local level, there have been no overarching authorities, public or private, to empower (or restrict) the medical profession on behalf of the wider health care system in the United States. The profession lacks clear-cut policy roles in the health care system.

Compared with the situation in countries with established policy roles for medical organizations in national health services or insurance systems, the medical voice also lacks political definition in the United States. The long-term social values and social costs inherent in delegating responsibility to the profession are at this time barely discussed in the United States—in terms of incorporating medical authority in the power structure of major health care corporations, or of the profession's public accountability for the standards and scope of services in major tax-supported programs, most notably Medicare.

Without a formal public-private partnership role to serve as a model, and without designated help from outside groups (at least as yet), the leaders of medical organizations, ranging from the AMA through a battery of specialty organizations, have been left to invent and negotiate new public roles on their own, insofar as they can, pulling their constituencies along with them. This is an enormously difficult task, because of the profession's status as an independent private enterprise that must struggle for public influence in an arena crowded with other players. Would-be professional reformers at all levels also have to work within a context of "negativity among their colleagues" (Mechanic 2000). An obvious first challenge for the profession is to be able to convince the public that it has different, perhaps loftier goals than other players. What does the medical profession stand for, over and above the actions of its individual members and self-interested actions by its associations? What does it wish to stand for? Can membership organizations, sensitive to the immediate problems of their constituents, ever represent the public's

interest, or even appear to do so? What can the profession or others do (if anything), to build socially responsible organizations?

Asking such questions in the abstract may engender vigorous philosophical debate and even generate consensus, but talk will not necessarily lead to action. For that, three practical issues are crucial. First, is the medical profession willing and able to work as a partner with managers, policymakers, and insurers—public and private? The jury is still out on this question. The current health care system has been going through so many changes that it is not even clear which partners are the ones to work with on a long-term basis. Second, does the profession have the organizational capability to act as a unified whole? And third, will influential critics be prepared to entertain the idea, even hypothetically, that professional organizations could be more than self-serving?

The enthusiastic specialization, subspecialization, and sub-subspecialization in American medicine over the past three decades, endorsed by multiple constituencies, has fractured the profession into multiple associations, leaving the core organization—the AMA—vulnerable. This process has been accelerated by the organization and funding of the health care system. The organizational parallel to pluralistic (rather than single-payer) insurance arrangements in the United States has been representative structures for the medical profession that are fragmented and opportunistic, based on specialty interests rather than on the profession as a whole. Moreover there is a long history of tension and mutual distrust between the medical profession and health care management (Stevens 1989). Even if we were to believe that valuable social goals could be furthered in the future through a strong, self-regulating medical profession with a mandate to act on behalf of the public, could the profession rebuild itself though robust alliances, both across specialties and with outside groups? And how could outsiders help?

Historical Reflections on Ideas and Agendas

The history of medical organizations is not much help in addressing these questions, except in underlining the cultural contingency of professional authority and emphasizing persistent themes of dominance and conflict. Much of the most interesting historical literature on medical organizations published since the 1960s focuses on battles won and lost—chiefly

by the AMA and its associated societies at the state and local levels, and by the medical schools (e.g., Harris 1966; Rayack 1967; Hirshfield 1970; Marmor 1973; Burrow 1977; Numbers 1978; Poen 1979; Starr 1982; Ludmerer 1985; Ameringer 1999). Though it has long been clear that some AMA policies—notably its opposition to government-sponsored health insurance for most of the last century—have not served the profession well in the long run (Stevens 1971), the impression remains that organized medicine has always fought government on a single agenda of professional self-interest.

Well into the 1990s, the AMA was portrayed as the change-resistant agent of a narrowly self-serving profession. A book about the AMA published by two knowledgeable Chicago journalists in 1994 included such chapter headings as "Looking after medicine's special interests," "Stopping national health insurance at all costs," "Playing politics with tobacco and the public's health," and "Bungling health policy on the AIDS epidemic" (Wolinsky and Brune 1994). Self-interest and ideals can, of course, coexist. However, there is not yet an authoritative history that takes seriously the possibility that idealism played any role in the profession's political decisions.

Involvement in a national health insurance system might have strengthened the role of medicine's professional organizations (though it might also, of course, have polarized the issues further). Theoretically, stronger central health care organizations would have forced professional leaders to reconceive the ideals and roles of medical organizations through years of rapid changes in bioscience and technology, social expectations of what medicine can do, complexity in the provision of care, rises in the costs of services, the information and consumer revolutions, and, not least, the increasing burden of chronic illness (Fox 1986; 1993). Such involvement also probably would have led to different scholarly appraisals of the profession's larger social roles than the ones we now have—perhaps more critical, perhaps less.

As it was, the American medical profession was shockingly unprepared to face the question of its public role in the late 20th century. There was no national system to provide a concrete framework for negotiation about the profession's new public place, or even a few monopolistic health care corporations that might have served a similar purpose. At the same time, the inherited ideology of organized medicine rested on outdated precepts—specifically, on patterns and policies that were developed in the first half of the 20th century, when doctors were primarily general

practitioners, health care costs were relatively low, and there was little health insurance, or even a health care "system" as we think of it today.

A century ago, it was not unreasonable to assume that providing a well-trained, science-oriented, increasingly specialized cadre of experts, working within the dictates of a professionally defined code of ethics, was a good and sufficient guarantee of the profession's obligation to serve the public. This ideological stance was represented by standardized educational programs in medical schools with a strong scientific base, support of biomedical research, a national network of licensing laws, standardized specialist training and certification programs, and national accreditation of hospitals. From today's perspective, the profession's public service agenda could be described as enhancing the quality of the doctor-patient relationship, improving scientific standards, and intervening at the national policy level where standards of patient safety were threatened. Thus the AMA supported food and drug legislation, which formed the basis of subsequent procedures for the regulation of new drugs and devices up through the present. In all of these respects, the profession seemed clearly to be serving public roles, and to be doing so remarkably effectively: unifying the medical profession, standardizing medical education, building the science base, and upgrading the competence of the average practitioner.

Nevertheless, it was evident by the 1920s that (using today's terminology) the competence of an individual physician was not, in itself, sufficient to guarantee good outcomes of care for everyone in an increasingly complex, expensive, and specialized health care system. Medical services were distinguished by their *dis*organization rather than by the organization necessary for the effective practice of specialized skills and techniques (Davis 1916). Actually, there was no noticeable connection between the roles and privileges of *any* profession and the effective provision of services to the public in their respective area of expertise (Whitaker 1922). Nevertheless, from the point of view of those who advocated a more collective, more egalitarian view of health services over the years, the professional self-government of American medicine ignored or subverted the larger, collective service aspects of health care provision (Stevens 1971).

There were thus two distinct threads to the profession's public service agenda in the 20th century, one representing an individual orientation and the other a collective orientation. While the AMA, then embodying organized medicine, supported funds for public health and clinics for

the very poor, and promised the public that any person seeking an individual doctor should find him or her to be reasonably well-trained in a defined field, to act in a principled way, and to give charity care where necessary, there were no similar promises about the quality of the health care system as a whole. As the effective organization, accessibility, and delivery of health services rested increasingly on multiple occupations and institutions, the medical profession isolated itself from other aspects of the system.

Organized Medicine and the Scholarly Critique

By the 1960s, when concern about access to care and inequalities in services came dramatically to the forefront of policy debates in health care, the society at large took for granted the profession's primary public agenda—promoting high standards of entry and education for individual physicians and encouraging biomedical research. Its second public agenda—opposing organized, collectivist health policies—appeared rampantly antisocial. Eliot Freidson noted in his landmark book, *Profession of Medicine* (1970), that despite claims that the medical profession was dedicated to high-quality services, no reliable information indicated that a service orientation was in fact widespread. A medical system based on professional autonomy had increased scientific knowledge, he wrote, but had also "impeded the improvement of the social modes of applying that knowledge," and encouraged the profession to be blind to its own shortcomings (Freidson 1970, 82, 371). It was but a short step from that position to the claim that professional authority seemed destructive of the public interest, at least in the United States.

A series of well-known critiques described the "autonomous" or culturally "dominant" roles of professions not only as outmoded but also as socially counterproductive (see Wolinsky 1988; Light 1988; Light and Levine 1988). Inside and outside the United States, scholars were observing that the conditions that gave rise to the institutions of professionalism were no longer the norm in industrialized societies (Johnson 1972), and that politics was not best served by the exercise of private interests, such as a powerful medical lobby. American political institutions, wrote Grant McConnell, "have in many ways been designed more to gain the acquiescence of power holding groups than to achieve a balance of public and private values" (McConnell 1966, 367). The professions were being

socially reclassified, moving down a moral continuum away from the role of benevolent agents of the public and toward that of self-interested players in the economic marketplace, as if they could not be both at once. Magali Sarfatti Larson set out to examine "how the occupations we call professions organized themselves to attain market power" (Larson 1977, xvi). Like other professions, medicine was relabeled as a social institution in the 1970s and 1980s. No longer seen as working quietly for the public good by producing well-trained experts, the American medical profession took on sinister, even antisocial characteristics in its role in the culture at large. Some influential critics and participants also revised its history from a glorious narrative of success to a more ominous tale of hubris.

Whatever the scholarly debates, the language of battles, rise, loss, decline, and defeat—associated with the ideas of dominance, autonomy, and authority—became part of more general, typically negative critiques of the medical profession. Historians created, and physicians (and others) accepted, an explanatory history of organized medicine in the United States based on the familiar cultural myths of paradise lost and vanquished heroes. Paul Starr's widely cited book of the early 1980s was perhaps the most compelling, and the most expropriated among medical groups, of the rise-and-decline interpretations. Starr (1982) depicted the rise of a "sovereign profession," imbued with cultural authority, which lost its legitimacy in the 1970s, and was then challenged by the "coming of the corporation." Concurrently, John Burnham (1982) described the 1950s and early 1960s—those years in which the profession could apparently do no wrong—as the profession's "golden age," and this phrase was appropriated into the myth. Eventually, it seemed, the forces of corporate America vanquished a heroic profession.

The language of decline and fall has been pervasive, as illustrated by two (of many) recent examples. "Fall of a giant" is how Elliott Krause (1996) summed up the American experience for medicine in his historical study of four professions in five countries since 1930. Kenneth Ludmerer (1999) depicted today's medical schools as "vassals of the marketplace," and used the creation and breaking of a "social contract" as a powerful organizing theme for the recent history of American medical education.

Criticisms of the profession's lack of a tradition of service in the 1970s and 1980s came at a time when service issues were urgent in the public eye, forced by the new conditions of rising health care costs, the failure of governmental health planning, the emergence of antitrust regulation

for professions, new Medicare policies and procedures, and later managed care. In theory, at least, the passage of the Medicare and Medicaid legislation in 1965 abolished the need for charity care by doctors and hospitals for the largest, most vulnerable social groups: the elderly and poverty-stricken. The profession's lack of service orientation in the 1970s can be attributed at least in part to the impact of these huge governmental financing programs, which removed charity care from the expected repertoire of medical practice. As an anonymous reviewer of this paper pointed out, this ubiquitous aspect of medical practice in the 1950s and 1960s (and in the rhetoric of ideal practice) was not replaced by another social good.

The medical profession became a convenient villain for failures elsewhere in health care policymaking. Its villainy was enhanced by the powerful narratives of failure that were built into conceptual explanations of the profession's larger social role: the decline in professional authority, with the medical profession overcome by the power of public disillusion and then by the more potent power of insurers. From the 1970s through the 1990s, as cost concerns marked U.S. national policy and the quality of care was seriously questioned, the idea of professional dominance as a negative social force merged neatly into contemporary (pro-market) policy critiques and helped to justify those critiques. The Clinton health plan deliberations of 1993–94 included little input from medical organizations, directly acknowledging their lack of political power and relevant social agenda as well as, perhaps, deficiencies in that policymaking process. The scenario was simple: Doctors were players in the economic marketplace who had gained inappropriate control of their workplace for their own financial ends.

At the same time that governmental efforts to provide health services for all people largely failed, professional organizations of all kinds lost credibility. In the process, the medical profession lost an opportunity to become a champion of modern, efficient health services through organizational innovation, and lost the government as a potential ally. Instead of the profession receiving a responsible delegation of authority from the government, doctors became conspicuous as adversaries, first of the government (notably in opposing Medicare in the 1960s) and later of managed care. The government, the corporations (the market), and the professions could be seen as three competing forces (see, e.g., Krause 1996). James Robinson described the recent history succinctly: The antitrust critique of professional institutions from the 1970s on

"ultimately contributed to the breaking up of the guild" and led directly to the "creative chaos of the moment" (Robinson 1999, xii, 29).

Reinventing the Public Mission

Critiques of medicine over the past 30 years appear at first to rule out a public mission for the medical profession in the future. However, since the mid-1990s, both the health system and the policy context have radically changed, making this a useful time for reevaluation. Managed care is not the panacea it once seemed to be. Medical groups are working with Congress and with state legislatures to regulate insurance practices and to protect the interests of both doctors and patients through patients' rights legislation. While organized medicine may have declined to press for a role as a delegated public agent under a governmental system for financing care in the past, this option is not precluded for the future. Today, it is easier to see than it was 10 years ago that public interest and professional self-interest are not necessarily, or even usefully, antagonistic.

It is in this context that the profession's strong, if one-sided, public service agenda for the last 100 years should be stressed. The forms of public service that predominated in the early years of the last century did not vanish; they have remained as subordinate purposes through the years and are available for expansion and updating.

Challenging the Myths

The medical profession and its critics need not continue their negative, perhaps self-fulfilling critique of the profession. Indeed, only by revising old ideas can there be a liberating language for this decade. Scholarly work on the utility and functions of language, narrative, and myth as part of the received history and ideology of the medical profession might usefully concentrate on the continuing mythological themes of strife and heroes, and on the long historical juxtaposition of "ideals" and "business" as rival descriptions (or mirror images) of America. The first theme provides the profession with a scenario for failure in the present; the second suggests conflict rather than cooperation with insurance and health care corporations.

Health insurers have come to symbolize business, in the sense that a necessary antagonism is assumed to exist between them and the "ideal" medical profession (Stevens 1998; Stone 1998), rather than a sense of shared mission, constructive mutual criticism, and even shared success, in the long run. Here, again, ideas from the first quarter of the 20th century linger, when the concept that commerce and ideals were antithetical social spheres (however counterfactual) was useful rhetoric for the rise of professions in the United States (e.g., see Haskell 1984). This set of beliefs informed the AMA's long opposition to "corporate" or "contract" medicine in the 20th century, through sanctioning the role of the medical profession as a source of idealism set against the market, on the assumption that the two were mutually exclusive. This notion lingers today in the belief that insurers and other large health care corporations will inevitably destroy the hallowed, selfless properties of "true" professionalism. Such instrumental, but largely unexamined, assumptions continue to structure behavior. For health care managers and researchers, as well as members of the health professions, thinking in terms of winners and losers, or victims and antagonists, may block the potential for confident, proactive, and innovative leadership in the future.

Identifying Partners

Reinventing professional idealism *in* the market, rather than in opposition to it, would require medical organizations to have available and willing partners. Visionary leaders within the profession may find themselves in a double bind. On the one hand, they are challenged to develop forward-looking public policies that move beyond divisive rhetoric. On the other, they may be thwarted in the search for national allies because of the decentralized, competitive power structures of the health care system and the inertia of federal policymaking (and at least some suspicion of their goals). Their policies, whether or not upheld by the membership at large, or seen merely as idealistic statements, drop into an implementation vacuum. In the process, efforts by some organizations to create real change in health care go unrecognized within medicine as a whole, and ignored by the health services research and policy communities.

For example, the American College of Physicians (ACP) developed and published a major policy paper in 1990, calling for a uniform minimum

package of insurance benefits for all, irrespective of residence or employment, and for financing mechanisms adequate to eliminate barriers to care (American College of Physicians 1990). In 2000, the Board of Regents of the combined ACP-ASIM (the ACP and American Society of Internal Medicine), representing 115,000 physicians, approved an extended policy statement, calling for a sequential, planned strategy for health policy in the United States. This would include the explicit public goal of having all Americans covered by an adequate insurance plan by a specified date; a "uniform, evidence-based package of benefits that would be available to all Americans"; the use of federal budget surpluses to expand health insurance to the uninsured; progressive financing; efforts to eliminate disparities in health care for those living in the inner cities; and programs of accountability to reduce medical errors. In this process, the medical profession should "embrace its responsibility to participate in the development of reforms to improve the U.S. health care system" through partnering with government, business, and other stakeholders (ACP-ASIM 2000).

Other medical organizations have developed public policy statements, and have sometimes signed joint statements, such as the one calling for health insurance for all Americans that was signed in 1999 by representatives of family physicians, pediatricians, emergency physicians, obstetricians and gynecologists, internists, surgeons, and the AMA (All Americans Must Have Health Insurance 1999). Some medical specialties are acutely aware of public policies because of their unique histories. For example, family practice, which became a credentialed specialty in 1969, has received substantial federal and state tax support, and its early leaders defined the specialty as part of a broader movement for social reform (Stevens 2001). However, it is not yet clear how national medical organizations can move beyond divisive rhetoric and rally their members to effective action without strong external partners.

In the short run, national charitable foundations and other nonprofit, policy-oriented organizations might fill part of the gap in national policy structures. Programs such as the Commonwealth Fund's Task Force on Academic Health Centers, the Open Society Institute's Medicine as a Profession Program (MAPP), the Robert Wood Johnson Foundation's Investigator Awards in Health Policy Research and other programs, the Institute of Medicine's Committee on Quality Health Care in America, and the National Quality Forum, among others, provide organizational bases for discussion both of health care policy and of the role of

professional organizations. While these not-for-profit institutions rely primarily on their claims to objectivity and moral leadership, and on their ability to foster consensus, sway public opinion, and mold expert judgment as levers for change (rather than the direct exercise of power in the health care system), these and similar efforts could prove vital to supporting and defining medical leadership in the United States for the foreseeable future.

Changing the Rhetoric

The medical profession itself is, of course, a diverse army of individuals with a wide range of skills, interests, and agendas. In the short run, a unifying body of rhetoric may be important in giving this army a sense of identity and purpose as members of one profession, and it is reasonable to expect that the major organizations will vie with each other to develop resounding phrases. Vilifying managed care has played this unifying function to some extent, and there have indeed been egregious problems and destructive controls on doctors and patients that needed to be fixed in the interests of both the public and professionals.

Medical organizations have used this tactic quite successfully. "Don't Let Big Insurance Ambush Patients' Rights," trumpeted an AMA advertisement in the *New Orleans Times Picayune* in April 2001, citing the "abuses" of managed care (American Medical Association 2001). Passage of patients' rights legislation in more than 30 states represents political success and may even restore some of the lost privileges and "autonomy" of the old fee-for-service medicine (Kesselheim 2001), although this might be seen as a retrograde step. However, this accomplishment may prove short-lived as managed care shifts to new forms, and battle statements do not mesh easily with the measured calls for public policy just discussed. Making managed care the "fall guy" for necessary (and overdue) rationalization of the medical marketplace seems misguided, even counterproductive, as a long-range strategy for any actual or would-be policy group.

What organizing rhetoric might be useful? Addressing this question offers an intriguing policy task (and intellectual challenge) not just for the medical profession but for any individual or group studying, working with, or attempting reforms of the major health professions. Available social science theories seem to sustain a conflict model for interorganizational relations. David Frankford and others have pointed out that the

language of power is structured into health care debates and scholarly analyses to such an extent that each type of power is thought to have a challenging or countervailing power (Frankford 1997; Schlesinger 1997; Light 1993). Under this model, the power of professional self-regulation is countered by increasing regulation of doctors by outside agencies. Buying into the concept of countervailing power is likely to structure expectations by suggesting (or rationalizing) an attack/defense agenda, thus narrowing the possible outcomes to winning or losing, and excluding the possibility of a win-win scenario.

However, assumptions are not immutable, and when images and stereotypes change, so may politics and policies (Morone 1997). The old rhetoric is tired and, in some ways, meaningless. For example, as other commentators have noted, the term "professional autonomy" in medicine seems to have shrunk and become a proxy for concerns about physician job security and income maintenance, while attacks on professional self-regulation as self-interest have left the term "self-regulation" without any coherent meaning and certainly without moral value (Wynia et al. 1999).

A recent article in the nursing literature reviewed models of positive identity developed for oppressed groups as relevant for the profession of nursing, so as to break negative stereotypes inherited from the past and liberate the profession from the "oppressor within" (Roberts 2000). Physicians, many of whom, like nurses, feel under siege from increased workloads and staff cutbacks, might be reluctant to declare themselves organizationally or individually "oppressed," despite their manifold complaints about the health care system. Nevertheless, the invention of new terms and the creation of new understandings of old terms are likely to be important elements in the process of change, whatever one's view about the future of professions.

There is renewed recognition in the scholarly disciplines of the importance of reappraising unexamined ideas that provide the conceptual framework in which we live: those words, ideas, and concepts that are "large in potential but not programmed," as the historian Thomas Bender put it (Bender 1997). New language can express cooperation rather than conflict, and act as an important bridge between participants with otherwise conflicting views. Working separately or together, policy analysts, consumer groups, medical leaders, and action-oriented researchers might address three tasks: to describe complex events in new ways, by drawing from common mythological understandings in ways that are helpful to

the present; to reinterpret recent history in the light of the major organizational changes of the past decades; and to develop new organizing language and new story lines to spur innovation.

Imagining the Future

A movement to reimagine the present, past, and future is already evident in a scattered body of work, largely outside the formal structures of the medical profession. In his study of the science and politics of drug regulation, for example, historian Harry Marks (1997) has reconceived the first half of the 20th century as the "era of organizational reform," and the second half as the "triumph of statistics." A rhetorical shift toward the value of statistical evidence in medicine, tailor-made for our present information age, provides one good way of conceptualizing organized medicine's role in the light of positive changes in the science base, and of opening up new possibilities for physicians in assessing and improving the health of communities. Discounting, for the purpose of argument, the very real difficulties of incorporating population health as an intrinsic part of medical education and clinical practice, such concepts could be more strongly framed by building on the medical profession's long tradition of support of biomedical science and public health.

In another example, Robinson (1999) has usefully ascribed "normality" to the turmoil in medical practice in the 1990s, by drawing analogies between health care reorganization and the deregulation of other sectors of the economy. He starts with the assumption that the old days are gone, that there is no going back to "unregulated professionalism," and that current upheavals are signs of "creative chaos," providing opportunities for innovation. In this scenario, the role of the medical profession is dynamic, not yet fixed, in terms of managing clinical practice in the future. To seize the challenge, medical groups, including professional associations, would have to work together across specialty boundaries, develop collective goals, buy into the culture of innovation, and (perhaps most difficult) cede management authority to effective leaders. The tone is one of moving forward, rather than of conflict or defeat.

Other scholars and reformers, too, are suggesting specific conceptual changes. Frankford argues for dropping the label "countervailing power" in favor of "participatory power," thus encouraging, at least at the symbolic level, different groups to work together more constructively in local communities (Frankford 1997; Frankford and Konrad 1998). Jordan

Cohen (1999) has been using the term "collaborative care" as a rallying cry for change in medical education. Marc Rodwin (1993; 1995) has stressed the nature and importance of the doctor's fiduciary role, a term that extends readily to the profession's wider social roles. Gregg Bloche (1999) has focused on the nature of clinical loyalties, raising the issue of wider organizational loyalties among physicians and to the public, as well as the traditional loyalty to individual patients. David Mechanic (1996; 1998) has chosen trust as an organizing concept for thinking about professionalism, including the importance of "social trust" in the broader roles and institutions of medicine. The concept of trust also weaves into the management literature and thus provides a potentially useful bridge between physician organizations and health care management. *Trust Matters* is the title of a book for managers trying to rebuild shattered organizational relationships (Annison and Wilford 1998). In a related vein, Norman Daniels (1998) has stressed the importance of building ethical health care organizations (including health plans), as well as ethical professions.

Language is not difficult to change. We live in a world of sound bites and buzzwords, with virtually instant communication. The idea of a public service role is not difficult to grasp, either. There is also some movement to create organizational alliances that might provide a more unified public voice for medicine. The AMA established its Commission on Unity in 1998. The Association of American Medical Colleges (AAMC) has been working to strengthen a unified public agenda for the medical schools. The specialty societies of medicine and the specialty certifying boards have collective organizations that could speak for them more forcefully in the future. These organizations are attempting to show, justify, and enhance their public roles, although constructive moves toward change by leaders of professional organizations may become mired in rampant pessimism among their various memberships, in competition among professional societies, and sometimes in suspicion of the leaders' motives. Medical organizations also need new rhetoric and public interest goals, apart from economic credentialing and consideration of the bottom line.

Unarguably, no one in the United States, rich or poor, would be well served in the future by a disorganized, if not demoralized, medical profession. Why? Because individual doctors make life-and-death decisions for (and with) individual patients; because medical organizations have years of experience and expertise in educating and evaluating doctors,

and this experience should be judiciously used; because there is a tradition of public service ready to be revived; and because no one outside the profession is capable of regulating the profession as well as the profession itself, though it may need help to change in ways that will enhance medical performance, confidence, creativity, and public trust.

Beyond Decline and Fall: Toward a New Public Service Ethos

What might a new public service role for the medical profession actually consist of ? Any specific agenda would be context-dependent. Major changes in legislation, massive shifts in the structure and behavior of health corporations (perhaps stimulated by government regulation or by fiscal incentives), or some combination of the two might generate new collective professional roles quite quickly, by incorporating the professional voice inside insurance arrangements, program policies, and organizational practices. Absent such changes, consideration of a new public service role would require continuous, subtle engagement by medical leaders and many others, including consumers. Models are needed—and here the health services research community could provide a major service. We need good scenarios for constructive empowerment, different forms of empowerment—and, for that matter, disempowerment—of professional organizations under different policy models in the United States, including alternative forms of universal health insurance. Other models might assume enhanced roles for organized medicine in the present system (e.g., greater involvement in clinical policies within, and as part of, managed care networks), in specific areas (e.g., quality improvement and assessment, or privacy of medical records), or in alternative scenarios for services in the future (e.g., the profession's role in crafting rules for managed care that are workable, innovative, and acceptable to all parties).

Potential roles for the medical profession depend on the competence of professional organizations to take a public leadership role, the relative willingness of the public (however defined) to recognize the value of a strong profession in furthering social goals, the existence of willing organizational partners (public and private), and the development of concepts and new language to build policy consensus. What structures for organized medicine seem the most promising for the future, and what the least? Can the AMA and the specialty societies, as representative

organizations of physicians, act as truly "public" agents? What will it take to get fragmented specialty groups to work together? If representative organizations cannot overcome the perception that they serve the immediate interests of their members and thus cannot serve the public, what other structures could be usefully invented? This promises to be an active time for professional organizations, and for the action-oriented researchers who work with them.

In theory, at least, there is a strong record on which to build new concepts and agendas. While doctors have long been blamed for the inadequacies of American medicine, they have also been praised for its successes. This historical visibility is an asset, for it gives the medical profession some legitimacy in claiming a future role in public and private policymaking. The positive traditions inherent in the profession's history could be emphasized, for there are residual strengths (as well as weaknesses) in past beliefs when crafting public policy for the future. Among today's questions are: what doctors can and should do for patients in health plans; how to establish common goals for high-quality clinical services; how to measure and improve those services; and how to ensure that all members of the population actually receive appropriate care. Theoretically, all of these questions flow directly from the profession's traditional, "individualist" agenda: ensuring to the public a trusting, ethical relationship between one doctor and one patient; making a commitment to provide care to those who need it; furthering public health activities; establishing national standards for education and training; and supporting biomedical science and technology policy. These historical agendas remain, to be adapted to meet new conditions.

The doctor-patient relationship, a core value of professionalism, is at the heart of current medical critiques of physician relations with managed care corporations. This essential commitment could be extended in many different directions, however. Since teams of health professionals rather than one doctor often care for individual patients now, the doctor-patient relationship could simply be expanded to encompass the performance and behavior of the whole health team—a logical updating to take account of changes in the way medicine is delivered. The policy implications of such a shift range from joint training and evaluation of the team to increased cooperation between doctors and other health care workers (including those involved with quality evaluation). Looking at patient care from a systems perspective is critical for error reduction as well. Similarly, the term "patient" might be extended to encompass the

local health system or groups of patients with similar conditions. In either case, the spirit of self-criticism (and learning from mistakes) that has long been a hallmark of medicine might be extended to the evaluation of specific health care systems, policies, or procedures—not as an attack on the power of the "system" or as a backhanded swipe at clinical practice, but as a natural extension of medical professionalism. The goal would be to learn from and improve care, rather than to punish or overregulate practitioners—a noncontroversial goal that is clearly in the public interest.

Even the profession's long-standing charity tradition, however archaic in its original practice of giving services to the poor without expectation of a fee, might be revived to serve the original goal of ensuring needed care to every member of the population, through whatever means available. In today's context, that would logically lead to strong political positions on universal health insurance coverage, or some other means of providing reasonable access to services for the whole population. This goal might also encompass policies for expanded administrative and planning roles for doctors in insurance and service organizations to ensure that services are being given and that they are of high quality. Similarly, the profession's traditional commitment to public health suggests an increased medical voice for better health at the community and national levels. Since the term "health" has long since widened to include coping well with chronic conditions, medical organizations might also pay more attention to how well patients are actually coping with such conditions, irrespective of their income level, ethnicity, or place of residence. Organized medicine could do more to encourage doctors to rate themselves and their teams by the health indices of the communities in which they work. Where those indices appear to be associated with factors extrinsic to the traditionally defined health system (such as improving education), the organizations might extend their collective moral reach in the interests of better community health.

The profession's traditional commitment to scientific standards also demands an adjustment in public roles, since major medical organizations are having to accept that other players have entered the standards business—including independent accrediting and credentialing agencies, such as the National Commission for Quality Assurance (NCQA) for health plans, and specialist credentialing groups outside the profession's nationally approved structure for physicians (see Millenson 1997). The development of patient-outcomes measures, clinical guidelines, and

novel ways of testing for competence in the practice setting has shifted concern about medical competence away from educational and credentialing alone to involve a host of experts outside (as well as inside) the medical profession. State licensing boards are flexing their muscles as alternative vehicles for private, professional regulation. The rise of bioethics involves a further group of professionals with a legitimate role in medical decision making. Medical organizations are trying to take account of these various shifts without defining them narrowly as power grabs by other players—not an easy transition to make. Again, the challenge is partly conceptual: to redefine "science" as a positive joint effort of numerous organizations and interests.

Medical organizations are becoming increasingly involved in defining and measuring medical service in the United States through specialty recertification and proposals for extension into the continuous evaluation of practice performance (see, e.g., Wasserman, Kimball, and Duffy 2000). Almost 90 percent of all practicing doctors (post-residency) are now board-certified specialists. In the future, evaluation might include appraising doctors' prescription patterns, appropriately early diagnosis, outcome measurements of patient care, effectiveness of the therapeutic team, and statistical analysis of the practice as a whole and of the larger group to which the doctor belongs. These action and others, if fully implemented, would bring American doctors firmly into the information age under private auspices. Logically, such actions would also generate demands by medical organizations (with or without cooperative efforts with insurers) for much better, more available data than exist at present.

Mark Schlesinger (1999) has suggested that it would be useful conceptually to explore the role of competing social institutions in dealing with issues that might otherwise be delegated to the profession. But if we stopped here in the analysis, we might buy into the downhill, post-professional-dominance conceptual model of the medical profession—that is, that a once-authoritative profession has lost much of its traditional cultural authority. Many players would need to be involved to extend professional responsibility by updating traditional public service goals, but the agenda itself would not necessarily be limited. Today's environment requires collaborative planning, management, and policy-making rather than conflicts; concerns about the health of populations as well as of individuals; and moral leadership in the allocation of scarce resources. Quality evaluation, a key aspect of professionalism, requires

links between medical groups and nonmedical evaluators—in universities, consulting firms, government agencies, corporate health plans, and (where relevant) the information industry. All these considerations of professional roles and actions have a direct bearing on social policy relating to the health of the public; for, taken together, they might realign public and professional agendas in ways that would be constructive for both.

No organization has yet taken the high ground of defining a consensus position of what, ideally, the American medical enterprise should be in the early 21st century. While this task may properly lie in the public policy realm—with legislators, consumers, entrepreneurs, and economists at the forefront—stronger involvement of the medical profession is not necessarily contraindicated. New professional agendas will require skillful negotiation between medical organizations and other players in the health care system, but it is not unreasonable to expect the medical profession to work with other groups, including congressional committees, to help establish basic principles for health care for all and invent a workable social contract from which innovation could take place. As caregivers in the most fundamental sense, literally and culturally, doctors are in a unique position. To create a better, fairer health system in this country, one step would be to re-empower the medical profession organizationally, recognizing that both power and its exercise would have different meanings than in the past.

The medical profession is only one potential source of leadership, of course. But there are strong reasons why the role of medical organizations as moral leaders could make considerable practical sense. The profession has long had an authoritative voice in American culture. Indeed, the very narrative of rise and fall was based on medicine as an American success story. Despite the gloom and doom expressed over managed care from the early 1990s to the present, doctors have not lost their normative roles in American society. They embody a huge reservoir of goodwill, inherited from the past. This is derived in various parts: from long respect of the doctor as healer; from the ideology of medicine as a public service and the doctor as hero; from the huge advances of scientific medicine in the 20th century, continuing through promises for the future; from claims for scientific objectivity; from the symbolic value of medicine as culturally suited to other American values (such as ingenuity, technology, and international superiority); and, not least, from the sheer visibility of national medical organizations, even in the absence of a unified governmental

health policy. At a practical level, the medical profession might also be easier to mobilize as an influential force in American culture than newer, less visible organizations.

Can medical organizations in the United States rally with sufficient speed to claim a new public agenda? Will they (or will they not) have external help to do so? Will organized medicine continue to be stigmatized (and stigmatize itself) by the myth of a profession in decline, if not defeat? At this point, no one knows. By raising and commenting on these themes, I hope to stimulate debate and research on medicine's future public roles among scholars, managers, and policy analysts, as well as within the medical profession, and to encourage cooperation across these groups.

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