Editorial

After Professionalization, What?

For the first time within my memory, the practice of medicine is becoming scary for reasons other than the occasional frights that arise in clinical work. I've had my share of terrorizing experiences when an obstetric patient bled profusely, a surgical patient went into shock on the operating table, a normally convalescing myocardial infarction patient developed cardiac arrest, and a postoperative patient died of massive pulmonary embolism. I've known self-recrimination and guilt for missing a cancer diagnosis, forgetting a Penrose drain in a wound, prescribing a drug to which a patient was known to be allergic, and setting a fractured forearm improperly. I've felt the wrath of disappointed patients and the anguish of a threatened malpractice suit.

These events—and others that I will not confess here—were plenty scary, but they did not cast a pall over my entire practice, undermine my confidence permanently, or make me afraid to go to work again. I don't recall them with relish or pride, but neither do I feel like a pariah or a criminal.

The new, scary element in medical practice is precisely this—physicians are now subject to disciplinary action, punishment, and prosecution for breaking regulations and violating laws that have less to do with direct patient care and clinical competence than with economic and administrative aspects of practice.

A recent issue of *American Medical News* carried front-page stories about prosecution of physicians for Medicare fraud and criminal conviction of dentists for violating antitrust laws.[1] There is a new spate of legislation—The Ethics in Patient Referrals Act of 1989 and the Medicare and Medicaid Fraud and Abuse Act—that even attorneys have not yet fully digested. It appears that a new set of unethical and criminal behaviors is being defined for physicians governing referrals, investments, and compensation, along with expanded applications of antitrust laws and Federal Trade Commission regulations in medical practice.

Combine all this with the laws and rules we already have governing licensure, peer review, quality control, utilization review, and fees, and it seems clear that a new generation of disciplined, sanctioned, criminalized, and defrocked physicians is about to be born.

How does it happen that society feels the need to resort to punishment to control one of its best-trained and most highly professionalized occupations? One with a tradition of commitment to public welfare and bound to a conscientious code of ethics? One that includes a host of Nobel prize-winning and publicly admired names? One whose ordinary members serve their patients in extraordinary ways? One that almost everyone will depend upon for skillful, personal care in their lifetime? Has medicine become so corrupt and untrustworthy that its villains must be hunted down like the mob? Are we in the process of developing a medical analog of RICO—the federal Racketeer Influenced and Corrupt Organizations Act?

Whatever the cause(s) of society's growing disenchantment with and suspicion of medical practice, a deep misunderstanding, full of paradoxes and dilemmas, is emerging, which can hardly be settled by coercion. What society seems to want is perfect medicine, practiced willingly, creatively, even tenderly, by market slaves. Physicians, on the other hand, want it understood that such medicine can be achieved, if at all, only by autonomous professionals who are inner-directed in their clinical work. Dehumanization of the medical encounter is a two-way street, affecting both patients and physicians.

One of the misunderstandings is the difference between reform and professionalization. Each is a social force toward change, but not necessarily the same changes. Society wants equity in the distribution of medical services, universal access, appropriateness, competence, humaneness, and cost-effectiveness and control. Medicine responds by building a bigger and better professional bureaucracy to control education, licensure, certification, accreditation, and interspecialty relations. Each is disappointed in the other.

Family practice, a microcosm within medicine and society, is a good example of this divergent evolution—although I don't think we saw it clearly

at the beginning. Many family physicians in the 1960s and 1970s were attracted by a new vision of humane and personal medical care, accessible to everyone, especially the underserved in rural and inner city locales, as well as other alienated and disenfranchised groups. The vision included a new emphasis on physician-patient relationships, comprehensive care, continuity of care, family medicine, behavioral medicine, patient advocacy, patient education, and the elements of primary care that were articulated so well in the Millis, Willard, and Folsom Reports.

Others, perhaps all of us at one time or another, were attracted by the need to transform and professionalize general practice so that it fit better into the mainstream of medical education and practice. To effect such a change included strengthening existing organizations (such as AAFP and its subsidiaries) and creating new ones (e.g., ABFP, STFM, ADFM, and the RRC) that could be integrated into the burgeoning mainstream structures (AAMC, ABMS, ACGME, COTH, ACCME, CMSS, and others).

Family practice grabbed the rings of reform and professionalization at a historically propitious moment and swung high and exhilaratingly for a while; now we are overstretched and in danger of losing our grip on reform in favor of an increasingly scary ride on the not-so-merry-go-round of professionalization. In this respect we are recapitulating the experience of the medical profession as a whole, which throughout its history in the United States seems to have preferred professionalization to reform.

Neither of these two social forces needs to be seen as inherently better or more important than the other, but each has a distinctive history. I know of no one who understands better than Paul Starr the economic and bureaucratic imperatives of medical professionalism in the United States. He traced the nineteenth century struggle for legitimacy (including licensure) based upon scientific knowledge and the creation of a "sovereign" profession that, through the accrual of authority over all matters of health, came to control the medical marketplace.[2] He wrote:

> The conversion of authority into high income, autonomy, and other rewards of privilege required the medical profession to gain control over both the market for its services and the various organizational hierarchies that govern medical practice, financing and policy.[p 21] . . . Professionalism serves, among other functions, as a basis of solidarity for resisting forces that threaten the social and economic position of an occupational group.[p 27]

He also describes how this accord between society and medicine is becoming unravelled in this last quarter of the twentieth century, with society trimming the profession's power by means of regulating accountability, competition, and cost containment. Ordinary physicians experience this change with anxiety and anger at chaotic bureaucratic meddling and interference in patient care. Such feelings are accurate and perhaps even more ominous than we know. Society's drive to recover power through regulation is taking on a more "Hammurabian" character; what remains to be seen is whether cutting off physicians' hands will produce the desired changes.

For the most part, physicians have not yet identified excessive professionalization as one of the root causes of their discomfort and persist in misdirecting their anger against the wrong targets, such as socialized medicine and "the government." As a group, we are still trying to use the old formula for success by ratcheting up a stiffer professionalism to prove to society how good we are and how deserving of authority and autonomy. In Biblical terms, society has asked for a fish, and we have offered a stone.

It is not my wish merely to seem apocalyptic in my appraisal; rather, I wish to support all family physicians and others who are spending time and energy on reform of medical practice. If Reinhardt's[3] projections are correct—that we will spend $1.5 trillion on health care by the year 2000—we all have a tremendous stake in seeing that every citizen is included justly. This is not likely to happen if physicians are more preoccupied with defending the profession and their own specialty's turf than working for fairness and appropriateness of medical care.

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References

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