Professionalism in the Practice of Medicine

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Abstract

Although medicine is universally recognized as the archetype of the professions, it can only be understood as part of the modern medical center, a dynamic social system consisting of the university, the hospital, the medical center and, most recently, corporate managed care. Such a view results in a portrait of medicine as a profession transformed, driven by huge and growing health care markets, its fate tied not only to state bureaucracies, but also to the dynamics of both health and non-health care businesses. The question asked here is how does such a radical change in medical practice affect medical education. Using methods of historical analysis, it appears that medical educators operate as though the educational process itself determines the values, and therefore the present and future behavior of their students. In other words, at the end of their formal education, doctors are fully formed professionals. However, from the analysis of this paper it can be concluded that the physician as an individual cannot function independently of the structure of the society and its general conception of the world. In the structure of medicine's present situation, the ethical standards of professionalism, as they are classically defined, cannot survive. Instead, modern medical graduates, much like their teachers and professional mentors, will be forced to adapt to a situation that is contradictory to the best traditions of medicine. How to stop this process is the urgent question. Three answers are presented.
Key Words: Professionalism, medical education, medical center, socialization for the profession, managed care.

PROFESSIONALISM has both precise and common usage definitions. It is easy to place medicine within the precise framework because it is universally recognized as the archetype, or epitome, of professionalism. Yet, to understand medicine in the full contours of its professional identity, it is necessary to see it in relation to several major institutions, especially the university, the hospital, the medical center, and most recently, corporate managed care. However, these are only the major structural components of medicine. How then can the implications of professionalism be incorporated into the process of medical education? To do so, in my view, requires a historical perspective which places medicine in the modern medical center, as a dynamic social system. What emerges is that medicine as a profession has been transformed and driven by huge and growing health care markets, with its fate tied not only to state bureaucracies but also to the dynamics of both health and non-health care businesses, even to what has been called the transformation of capitalism itself (1).

The question then is, how does such a radical change in medical practice affect medical education? In my experience, medical educators operate as though the educational process itself determines the values, and therefore the present and future behavior of their students. This presumes that the future doctors, armed with the intelligence and personal, humanitarian values that determine their selection and reinforced by the dedication to the best of professionalism in their medical school training, can therefore emerge at the end of formal education as fully formed professionals. As such, they are ready for the marketplace of contemporary practice, able to preserve their professional values against the corruption of contrary forces. My answer to that is encapsulated in Henry Sigerist's warning, seventy years ago, that medicine has been determined (2) "in different peri-

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ods of history, by the structure of the society at the time and by its general conception of the world. . . . The physician's position in society is never determined by the physician himself but by the society he is serving." In other words, the physician, as an individual, cannot expect to function independently of the structure of the situation in which he works. What then are the determinants of professionalism in contemporary society?

The Professions: Defined

Scholars agree that professions developed out of the medieval guilds and universities. The earliest use of the term recorded in the *Oxford English Dictionary* dates from 1541. There is no corresponding term in any language of the ancient world (3, 4). Yet doctors, clergymen, and lawyers, the basic professions of Western society, were part of earlier societies. Today's medical graduates, for example, take the Hippocratic oath, which dates from the fifth century, B.C. (5). Therefore, in any discussion it is necessary to define these and other professions as they now function.

A profession is distinguished from nonprofessional occupations in two fundamental ways. First, it contains an abstract theoretical knowledge base that requires extended formal training. Second, the welfare of the community is enhanced by the professional practitioners. All studies of the professions agree that only those occupations which combine these two qualities in significant measure qualify fully for professional status in our society (6–11). Two other characteristics have long been associated with the professions. First, their practitioners form a distinct social group, classified as such both by the practitioners themselves and by the society in which they operate. The basis of this social group is in their professional activity and not some other social or economic attribute. Second, the social group itself is organized into an association which establishes formal rules and informal practices of behavior. The association subscribes to ethical standards, disciplines its own members, and thus preserves the integrity and independence of its members.

One can elaborate on this definition, but for the purposes at hand, no further elaboration is necessary. Instead, I propose that these two premises, an extended knowledge base and a commitment to function as part of a social contract for the welfare of the community, should be viewed as the hub of a dynamic social system, subject to constant pressure from competing forces in an ever-changing society. I propose further that this social system is guided by dynamic inner requirements to establish and maintain equilibrium, much like other types of systems (12–14).

The medical center is the modern expression of the sum of medicine's relationships as a profession. Briefly, the modern medical center is a conglomerate, bringing together medical institutions of diverse types and functions, under an administration that is unified to some degree, for the common purposes of medical education, medical care and research (15). Historically, Columbia-Presbyterian, in 1928, was the first organization of this type; since then, it has become the dominant model for American medical schools. I will begin by abstracting, in a visual form, a systemic arrangement of the vital components of the medical center as a social system. Such a system (Fig. 1) builds from a relationship between the medical profession (I) and the community (II).

The Medical Profession in Interaction With The Community It Serves

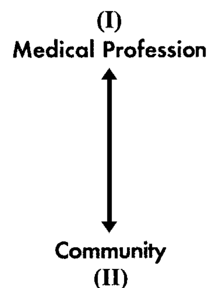

Fig. 1. The medical profession in interaction with the community it serves.

Fig. 2 illustrates the distinguishing characteristics of medicine as a profession. Knowledge and its application serve as the roots of the profession, and are the natural source for quite different behavioral modes. This is illustrated in Fig. 3. Knowledge forms an axis with the cognitive-rational mode whereas the application of this knowledge serves as the active-affective axis (Fig. 3).

The medical center is the site at which three main functions, teaching, research, and clinical service, are presumably coordinated. All of these components can be combined into an octagonal model of the medical center in a state of balanced tension (Fig. 4).

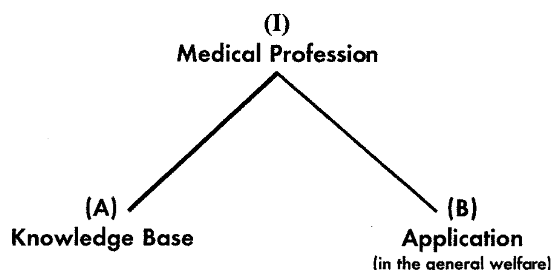

Fig. 2. The distinguishing characteristics of the medical profession.

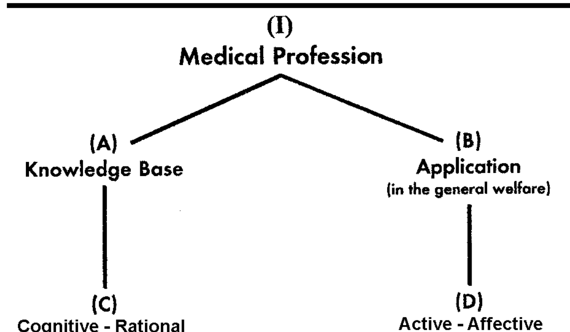

Fig. 3. Associated behavioral modes of professional attributes.

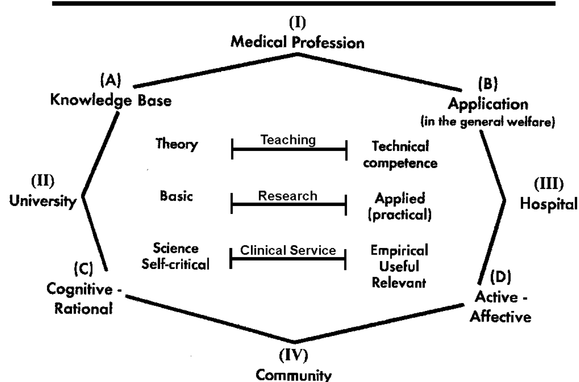

Fig. 4. The medical center as a social system.

I will use this model to illustrate how the separate structures that have developed to fulfill the main functions of medicine are integrated into one balanced form. Specifically, the knowledge base must underpin all aspects of the teaching and research components. The university (II) serves as its main underlying social structure and source of control. We know historically, for example, that when professions have tried to exist entirely outside the university, they have tended toward the vocational, the narrowly practical, and the commercial (16–18). Thus, the university, when it is effective as an institutional base, strongly influences the other axis, and its institutional base, the hospital, to be universal and not particularistic, to be self-corrective and technically valid, and not just utilitarian (3).

The context for this social system is the community in which it exists. This source of influence is never at rest. One can identify how the community has exerted its influence on both the university and hospital together and on each separately (19–21). However, for more than half a century, dating roughly to the beginning of the twentieth century, the community accepted the notion that it was the development of scientific medicine that best served the welfare of society. As a result, there was a long period in which medical institutions, both in their teaching and service aspects, remained insulated in many important respects, from direct influence by the community. The authority of physicians, during this period, was virtually without question. Professional autonomy was at its strongest.

During the two decades from 1960–1980, however, the view of the community was drastically revised and shifted to the service oriented, B to D axis. The development of knowledge which, in the so-called golden age of scientific medicine had been dominant, lost its overwhelming primacy. This is the beginning of what Kenneth Ludmerer, in his landmark study of medical education, calls the second medical revolution of the century (17) “the breaking of the social contract.” No one, in my view, could have anticipated the consequences of the signal event from which this revolution emerged, the Medicare and Medicaid acts of 1965. “The clinical activities of medical schools began to hypertrophy, swelling out of proportion to their other duties.” Ludmerer wrote, “Clinical services rapidly grew to become their most conspicuous activity and most important source of income. In the process, their link to the university weakened, their commitment to academic values decreased, their tradition of charity eroded, and they became enmeshed more firmly than ever in the health care delivery system.”

The paradox is that professionalism, in its purest form, is assumed to be a value construct, which emphasizes the ethical qualities of medi-

cine's social contract. However, the octagonal model in Fig. 4 clearly indicates that it is the institutional structure of the medical center organizations which is the determining variable. The recurring concerns and the resulting programs of educational reform (22), according to this thesis, are based on the clash between ideology (value systems) and social structure (22, 23). As I stated in an earlier paper (23),

> The corporate bureaucracy of the medical school has become an ever-expanding institution, requiring a flow of resources that exceed the income which is available from education itself (tuition, competitive training grant programs, or subsidies, such as Medicare-Medicaid). Thus the medical school is forced to maintain itself indirectly on resources that are allocated to support the goals either of research or of the technology of the specialized tertiary care typical of teaching hospitals. By the very definition of this situation, educational values become subordinate to the requisites of the organizational structure of the medical school, and therefore to policy that is determined by external groups who provide the means and regulate the activities of the major persons within the institution.

Among such groups, managed care has taken the dominant place in the current health care system of the United States. No discussion of medicine today is possible without attention to its transforming effects. According to the American Association of Health Plans (AAHP, the trade organization for HMOs, located at 1129 20th Street NW, Suite 600, Washington, DC 20036) the most recent available figures (as of the end of 1996) estimate that 80% of potential commercial enrollees (or 70% of the total population) are enrolled in managed care programs (24, 25). Managed care is defined as (26): "Health insurance plans intended to reduce unnecessary health care costs through a variety of mechanisms, including: economic incentives for physicians and patients to select less costly forms of care; programs for reviewing the medical necessity of specific services; increased beneficiary cost sharing; controls on inpatient admissions and lengths of stay; the establishment of cost-sharing incentives for outpatient surgery; selective contracting with health care providers; and the intensive management of high-cost health care cases." This definition includes Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

Without question, managed care has radically changed the institutional structure of medicine. Instead of the dominance and autonomy of physicians and voluntary hospitals that had characterized medicine at the beginning of the twentieth century, power has been transferred to the huge health care conglomerates that increasingly represent managed care programs. The irony is that prepaid, capitated medical care for broad-based populations originated in the 1920s and was represented by non-profit organizations like Kaiser-Permanente (1945) and Group Health Cooperative of Puget Sound (1947). The major objectives of these early variants of HMO were to increase access to quality health care at a low price, with a strong emphasis on primary care and prevention. The profit potential of this type of organization, however, after a long intervening period, has more recently attracted the establishment of publicly-traded, for-profit corporations in a marketplace that has grown phenomenally in recent years (25).

The challenge of managed care for medicine as a profession and for medical education specifically is daunting. My octagonal model is, in its present form, obsolete. For-profit managed care, as an institution, threatens to overwhelm the medical center, dominating the whole system. The most pressing question for medical education today is whether it will respond to this challenge by addressing the structural problems of organization, the sources of authority and allocation of resources, the power centers of decision making. Or will the approaches be limited, as they have been so frequently in the past, to calibrations of curriculum that reflect ideology without reference to the realities of institutional structure?

In the definition presented earlier, professional associations were responsible for "maintaining ethical standards that preserve the independence of its members." In medicine today, this function has been overwhelmed by the demands of managed care. The leaders of medical education, in turn, proceed as though the practice of medicine has not changed. They turn their graduates loose after formal training that offers virtually no preparation for the current realities of medical practice, as though scientific and clinical expertise will be enough. In this process, I do not see how the ethical standards of professionalism as we define them here can survive. Instead our graduates will be, like

our leading teachers and professionals, forced to adapt to a situation that is contradictory to the best traditions of medicine.

A more thorough analysis of the incongruity of combining the managed care industry for the delivery of high quality medical care with the requirements of ethical medical professionalism has appeared elsewhere (27). It should be clear, nevertheless, from even this superficial analysis of the social system of the modern medical center, that the commodification of health care is a violation of the basic requirements of medicine as a profession. At risk is medicine's centuries-old contract to act as a profession dedicated to the use of its scientific knowledge to serve the general welfare of the community. Without that contract, professionalism is dead.

Within the broader context of the sociological analysis of health care, this discussion fits the pattern associated with Parsons (28), expanded to account for power relationships and the massive change in the social context of medical practice. Put another way, I have described a profession which "possesses power as expressed in social organization, in the way people think about and act regarding health care, as well as its control over medical work itself" (1). The question then asked is, what happens when such a profession is transformed from a situation in which physicians were petty bourgeois entrepreneurs into one in which physicians are part of huge and growing health care markets? One answer leads into the forest of theory, from Weber, Marx, Durkheim and others (1). Here, however, we will ask a more urgent question: what can be done?

The first answer, in my view, is to maintain the standards and values of the key institutional structures which have shaped medicine as a profession. The university, by its nature, does not allow research enterprise to be bought. If the medical school allows its science infrastructure to become part of for-profit industry, the rules of science are violated. Science depends on the freedom to collaborate, to share, and to publish. Science does not fit into the secrecy and the protective rules of business enterprises. This is hardly a novel argument. Fifteen years ago, eloquent and incisive arguments were published in four books, with the same warning (16, 29– 31).

Second, clinical medicine must be guided by the rule that any decision made by a physician on behalf of the patient must be based on the available knowledge and evidence. Cost-benefit is not a fundamental guidepost of clinical medicine.

Third, medical education must add reality-preparation for the complex, power-driven competition in the medical marketplace. Health care is a social good. It may even be a social right. It is not a commodity.

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